1999, nearly a third of all recognized pregnancies ended in abortion, either induced or spontaneous, yet only 4 percent of all maternal deaths during that time were associated with any type of abortion.[3]

Dr. Marchetti asks why dilatation and evacuation is not used to evacuate the uterus in the case of fetal death. In fact, the procedure is routinely used for that purpose. She also points out that the difference between the death of a fetus in utero, out of sight, and in full view during a destructive procedure is the degree to which the event offends our sensibilities. We agree.

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1. Reardon DC, Ney PG, Scheuren F, Cougle J, Coleman PK, Strahan TW. Deaths associated with pregnancy outcome: a record linkage study of low income women. South Med J 2002;95:834-41.
2. Gissler M, Kauppila R, Meriläinen J, Toukomaa H, Hemminki E. Pregnancy-associated deaths in Finland 1987-1994 — definition problems and benefits of record linkage. Acta Obstet Gynecol Scand 1997;76:651-7.
3. Chang J, Elam-Evans LD, Berg CJ, et al. Pregnancy-related mortality surveillance — United States, 1991–1999. MMWR Surveillance Summ 2003;52(SS-2):1-8.

Paying Physicians for High-Quality Care

TO THE EDITOR: We suggest two additions to the list of challenges facing the innovative "payment-for-performance" initiatives described by Epstein et al. (Jan. 22 issue).[1] Current payment-for-performance programs focus on underused services such as retinal and foot examinations for patients with diabetes and the administration of statins for patients with cardiovascular disease, because it is politically awkward to pay doctors a bonus for doing less of something (even if less means better care). To address another large category of quality problems — overuse of nonbeneficial services — different models of "paying for high quality" will need to be designed.

Although physicians with high-quality performance might get bonuses from payment-for-performance programs, they will not necessarily realize higher margins. The staff time needed to review charts, audit data, and deliver the additional services needed (in the case of "underuse," as noted above) means that even if a bonus is earned, the net impact on the margin in a given physician's practice is often neutral or negative.[2]

These laudable early efforts to channel the attention of physicians to the quality of care are transitional models. Physicians must work with payers and purchasers on payment systems that drive a more comprehensive quality agenda and make a better business case for high-quality physicians.[3]

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1. Epstein AM, Lee TH, Hamel MB. Paying physicians for high-quality care. N Engl J Med 2004;350:406-10.
2. Maguire P. As they struggle to improve quality, HMOs try a new incentive: bonuses. ACP-ASIM Observer. June 2001. (Accessed April 8, 2004, at http://www.acponline.org/journals/news/jun01/bonuses. htm.)
3. Reinertsen JL, Gosfield AG. Doing well by doing good: improving the business case for quality. June 2003. (Accessed April 8, 2004, at http://www.qualityhealthcare.org/IHI/Topics/Improvement/ImprovementMethods/Literature/DoingwellbydoinggoodImprovingthebusinesscaseforquality.htm.)

TO THE EDITOR: Epstein et al. would have us conform to static norms and care for uniform patients, with money as our primary reward. We would prescribe only the "right" drugs, use only the "best" techniques, and implant only the "best" devices, as determined by formularies, pundits, and industry-sponsored studies. With this approach, all postmenopausal women would have been prescribed hormones that are now contraindicated. No patient would be "allergic" to all antihypertensive agents, refuse statins, or prefer aspirin therapy to monthly measurements of the international normalized ratio.

Statistically valid indexes are poor measures of the quality of medical care. Economic incentives are always subject to "gaming," inappropriate manipulation of data, and "cherry-picking" of patients by physicians and groups more interested in making money than in providing good care. Most physicians (and other professionals) work for rewards that are more important than money, including the respect of their patients and peers and the personal

satisfaction of a job well done. Medicine is still an art, in spite of basic scientific and health services research. We need better "artists," not more corporate "art critics."

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TO THE EDITOR: Many practicing primary care physicians have expressed concern about the new National Health Service contract.[1] What has been special about primary care in the United Kingdom has been the personal touch and the pleasure of doing things that cannot be counted. The emphasis is now being changed, and one fears the impact that "target oriented medicine" would have on patient care.

If one looks at hypertension as an example, our payment will depend on our providing documentation that a percentage of the patient's blood-pressure measurements are below a defined numerical value. We will have to work out when we will measure blood pressure to coincide with the peak effect of the medications. This approach takes the challenges away from a complex problem when good 24-hour control should be our aim.

No one doubts the value of self-reflection, but when most consultations have a price tag attached to the information that is documented, our role will be trivialized. We will have to work like managers — "milking figures" for targets.

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1. The NHS Confederation. NEW GMS contract 2003: investing in general practice. London: British Medical Association, February 2003.

TO THE EDITOR: The article by Epstein et al. recommends bonus payments to physicians for high-quality care, with the use of a variety of possible strategies. They state that incentives "will put greater direct responsibility on physician practices to 'get it right the first time.'" What is not mentioned is the key factor in precluding thoughtful, comprehensive care delivery: the poor compensation for cognitive services that forces practitioners into time-limited efforts. Making ends meet despite rising costs and shrinking revenues is a difficult challenge; the expansion of noncompensated paperwork markedly exacerbates the situation. The multiple plans, formularies, coverage, consultant panels, and involuntary shifting of patients between plans (or to no coverage at all) truly makes our current medical structure the "nonsystem from hell."

What is really needed is a revision of our health care delivery system to achieve a structure that will enhance the opportunity to deliver high-quality care, not diminish it, as is currently the case. In my opinion, a well-done, creative, single-payer system has the best opportunity to accomplish that goal.

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THE AUTHORS REPLY: We agree wholeheartedly with Dr. Verdery that most physicians work hard for the respect of their patients and peers and the personal satisfaction of a job well done. In spite of these incentives, however, there is abundant evidence that the quality of care is less than optimal and can be improved. Financial incentives may play a positive role. We recognize that the lack of centralized universal insurance coverage may exacerbate problems with the quality of care, as noted by Dr. Graap. However, even in Canada, which has such coverage, no one has claimed that problems in the quality of care have been eliminated. We doubt that the adoption of a single-payer system will be sufficient by itself to produce the highest quality of care.

Concern about programs that pay for quality, as voiced by Dr. Mahendran, are understandably even greater in England, where the new contract for general practitioners has established incentives for high-quality performance that could determine up to one third of a general practitioner's income. Forthcoming changes in the British health care delivery system may provide valuable insight into the broader costs and benefits of this approach.

Finally, we agree with Ms. Gosfield and Dr. Reinertsen that quality indicators might best include measures of "overuse" as well as "misuse" and "underuse." We expect such indicators to be incorporated in future years. We worry that these writers are correct about the costs of higher-quality care. In some instances, providing better care will cost physician practices additional resources. Unless additional payments for better-quality performance

are set sufficiently high that they truly create financial incentives, they are unlikely to be effective.

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State Initiatives to Control Medicaid Drug Costs

TO THE EDITOR: Mello et al. (Feb. 5 issue)[1] describe initiatives to control states' expenditures for drugs, including multiple mechanisms for forcing physicians to obtain approval to prescribe drugs. Physicians working to provide appropriate treatment thereby become grubbing middlemen between Medicaid and manufacturers, having to negotiate or plainly beg for coverage. Although the goal of prior-authorization programs is to reduce costs by eliminating inappropriate prescribing, the programs impede both inappropriate and appropriate prescribing. Physicians facing complex medical decisions in the small amount of time between visits must shift their attention to discuss indications for drugs with insurers. These clerical tasks hinder care.

Physicians should focus on patients and medical decisions. Useful alternatives to authorization are available in decades-old technology. Formularies of manufacturers, payers, and providers could be updated, integrated, and queried with computer networks. Creating this system requires a large and coordinated effort, which would perhaps best be undertaken in the public sector. Standards for electronic records and health care communications will facilitate these developments. Powerful systems will combine clinical and demographic data to help physicians identify documentation and indications for drugs. The decision to pit technology against this problem seems straightforward.

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1. Mello MM, Studdert DM, Brennan TA. The pharmaceutical industry versus Medicaid — limits on state initiatives to control prescription-drug costs. N Engl J Med 2004;350:608-13.

Refractory Thrombocytopenia despite Treatment for Rattlesnake Envenomation

TO THE EDITOR: In our review article (Aug. 1, 2002, issue),[1] we provided an algorithm for the treatment of pit-viper envenomations with Crotalidae Polyvalent Immune Fab — Ovine (CroFab, Protherics). We now must express our concern that treatment based on this algorithm may not reverse the thrombocytopenia frequently associated with timber-rattlesnake envenomation, as suggested by the case described below. Timber-rattlesnake venom was not used as an immunogen in either the old equine antivenom (Antivenin [Crotalidae] Polyvalent, Wyeth Laboratories), which is currently available only in limited quantities, or the new ovine antivenom (CroFab).[1]

A 38-year-old man was bitten on the left hand by a timber rattlesnake and presented to the emergency department within one hour. He had no underlying medical conditions and no history of snakebite. He had a single fang mark with minimal ecchymosis on the left hand near the second metacarpophalangeal joint. The hand and forearm were swollen, with marked tenderness. Vital signs were within normal limits. Initial laboratory studies included a complete blood count with a differential count, platelet count, coagulation profile (fibrinogen level, prothrombin time, and activated partial-thromboplastin time), creatine kinase measurement, and basic metabolic profile. The platelet count on admission was 157,000 per cubic millimeter. When repeated about five hours later, the platelet count was 28,300 per cubic millimeter.

On the basis of the clinical findings, treatment was initiated with CroFab. Despite treatment with large quantities of antivenom, the patient continued to have thrombocytopenia. On the third hospital day, his platelet count dropped to 590 per cubic