Most bronchoscopy has been done on a fee-for-service basis where both investor-owned and non-profit community hospitals have incentives to encourage high reimbursement procedures. In most hospitals, bronchoscopy escaped any quality assurance review except cursory inspection of reimbursement claims by insurance companies. Those done at public expense in government hospitals escaped even this audit. In the early 1970s, when fiberoptic bronchoscopy grew rapidly, quality assurance committees were in their infancy. Physicians did much to assure quality in their practice, but many would have identified quality assurance as an engineering expression.

Organizational changes occurring in medicine are now introducing scrutiny. JCAH inspection criteria are more stringent each year. To avoid question, our tissue committee now reviews the indications for bronchoscopy, the pre- and post-bronchoscopy diagnoses, and the specimens obtained. A small informal telephone survey suggested that such review is still uncommon. That will likely change. It is now common for payment to be made on a per capita basis to profit-minded health maintenance organizations (HMO) or independent practice associations (IPA) whose management seeks to curb expenses by limiting referrals to specialists. For example, some IPA's return more of the money initially withheld from participating doctors to those primary care physicians who keep their cost-per-patient low. HMO utilization committees review their gatekeeper physicians' requests for subspecialty consultation and hospitalization. Gatekeepers are given incentives to reduce HMO expenditures, even to the point of sharing unused premium dollars designated for consultant care and hospitalization. These stratagems reduce unnecessary bronchoscopy, but may discourage or disallow appropriate procedures.

These corporate business decisions will increasingly affect referrals because, among physicians under the age of 35, 40 percent of male and nearly 60 percent of female clinicians now work for salaries. The swing toward salaries will accelerate because the surplus of physicians created by federal aid to medical schools from 1965 to 1980 reduced the number of patients available to each physician nearly 30 percent between 1975 and 1990. The coming market will reflect these changes. More HMOs, IPAs, insurance companies, and investor-owned hospitals will negotiate contracts for endoscopy at reduced rates. The contracts will define the clinical circumstances and diagnoses for which payment for bronchoscopy will be made. There will be a new potential for abuse in these prospective payment arrangements. It will lie with the incentives to skimp on necessary consultations and procedures.

Competition is the major vector that impels whatever unnecessary bronchoscopy is being done. In a market saturated with physicians, that vector will reverse and force subspecialists and gatekeepers alike to adopt economies of practice. Pulmonologists are already entering into financial agreements that make unnecessary endoscopy self-defeating.

The philosopher economist, Adam Smith, (The Wealth of Nations), believed that characteristics intrinsic in a competitive economy (ultimately) produce social benefits from unsavory individual intentions. Smith was the eighteenth century's foremost spokesman for the constrained vision of man. Thomas Sowell emphasizes another hallmark of this constrained vision: man deals in tradeoffs, not solutions. Physicians must be wary of any reimbursement tradeoff that compromises their position as patient advocate.

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REFERENCES

Communications to the Editor
Legal Issues in Cardiopulmonary Medicine

To the Editor:

Practicing cardiopulmonary physicians have numerous concerns. One major issue that has not been addressed by the ACCP is legal questions and concerns involving professional liability. Although there seems to be a widespread feeling among our membership that something should be done about the medical malpractice dilemma, there are no data on which to make intelligent observations or sound recommendations.

For most doctors, the concern seems to be a spiralling malpractice premium that increases almost yearly. Yet another concern is the expanding interpretation of tort liability by the courts of this nation. For example, a New York court recently found a psychiatrist liable for having had sex with a former patient.1

A very recent survey by the American College of Obstetricians and Gynecologists found that more than 70 percent of all responding OB-GYN specialists had at least one lawsuit filed against them in their professional careers. Twenty-five percent had been sued three or more times.2 Fifty-two percent involved obstetrics; 45 percent of the claims involved gynecology with an average payout of $64,000. Many of these claims involved the failure to diagnose simple early breast cancer.

It is this author’s impression that the majority of claims in cardiopulmonary medicine/surgery would arise from the following: 1) interventional procedures that can only be described as “legally risky behavior”;2 2) misdiagnosed and mismanaged pulmonary emboli; 3) major cardiothoracic injuries during surgery; or 4) issues in lung cancer. But only reliable data could confirm or negate this impression.

It would also be useful to assess by questionnaire the extent of the malpractice problem that affects cardiopulmonary physicians, and if in the area of occupational lung disease there is equal compensation for equal disability, or whether the present tedium, time-consuming, expensive, and unjust litigation for occupational lung disease should continue.3

A recent New York Times article indicated that medical malpractice has become a $4 billion industry and can have severe psychological affects on the physician.

It is my opinion that a questionnaire on the legal aspects of medical practice would be most useful.

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1 Judge finds psychiatrist liable for sex with a former patient. The

New York Doctor, April, 1989


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Prevention of Recurrent Pulmonary Embolism

To the Editor:

In a recent paper we reported our experience with heparin therapy in patients with venous thromboembolism.1 In our series, early recurrences were seen in seven of 36 patients (18.4 percent) with an original diagnosis of pulmonary embolism (PE), and in five of 83 patients (6 percent) with deep venous thrombosis (DVT) of lower limbs. Theoretically, higher doses of heparin would have decreased this recurrence rate, but also the risk of bleeding strongly correlates with the mean total daily dose of heparin.

Several years ago, Sullivan et al demonstrated that adding dipyridamole to warfarin in patients with mechanical valve prostheses may confer additional benefit without a higher bleeding rate. Since then, several authors recommend the combination of anticoagulants and dipyridamole in preventing arterial thromboembolism.2 In order to investigate whether combined dipyridamole heparin therapy would be safe and effective, we performed a prospective, double-blind randomized study in patients with venous thromboembolism. The main objective was to determine whether the risk of recurrence of PE associated with heparin therapy could be reduced, but without a greater risk of bleeding.

Since January, 1988, 93 patients were diagnosed with acute venous thromboembolism in our hospital. Only those patients having an adequate course of heparin therapy were included; therefore 11 of these patients were not included (because of clinically massive PE in three; recent intervention in three; thrombocytepenia in two; previous bleeding in two; hematoma in one patient). Additionally, another seven patients were excluded after randomization: four patients with PE because they refused venography, three because of technical reasons.

A total of 75 patients entered into the study: 37 men and 38 women, aged 21 to 84 years, mean 63.7. A total of 14 patients had clinically apparent pulmonary embolism, and 61 patients had deep venous thrombosis on lower limbs. As in the previous study, all patients had objective tests to confirm the diagnosis (conventional venography and ventilation-perfusion lung scan, both baseline and eight days after therapy). In addition to heparin (also in the same dose), patients were randomized to receive either the anticoagulant heparin or dipyridamole, as well as a placebo. Patients were monitored for a total of 8 weeks, and were compared with previous experience in the 136 consecutive patients who received heparin alone.

Table—Baseline Characteristics, and Results of the Double-blind Trial

<table>
<thead>
<tr>
<th>Heparin +</th>
<th>Heparin +</th>
<th>p value*</th>
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<tr>
<td>dipyridamole</td>
<td>placebo</td>
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<th>Baseline characteristics</th>
<th>Patients, number</th>
<th>with venous thrombosis</th>
<th>with pulmonary embolism</th>
<th>Age, years (mean ± SD)</th>
<th>Recurrences of PE</th>
<th>Bleeding complications</th>
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<tbody>
<tr>
<td></td>
<td>40</td>
<td>34</td>
<td>6</td>
<td>63 ± 13</td>
<td>4 (10%)</td>
<td>7 (17.5%)</td>
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*Chi-squared test was used