

From the EDITOR



Dr. Wulf H. Utian, consultant in women's health and reproductive endocrinology, has served as Editor-in-Chief of *Menopause Management* since its inception in 1988. The Arthur H. Bill Professor Emeritus of Reproductive Biology and Obstetrics and Gynecology, Case Western Reserve University School of Medicine, he is also Consultant, Obstetrics, Gynecology and Women's Health Institute at the Cleveland Clinic, and Executive Director of The North American Menopause Society (NAMS). He is Chairman of the Advisory Board of Rapid Medical Research, Cleveland. He received his medical degree from the University of Witwatersrand, Johannesburg, South Africa, and his PhD from the University of Cape Town, South Africa, and is a Fellow of the Royal and American Colleges of Obstetricians and Gynecologists, as well as the International College of Surgeons. In 2007 he earned the DSc(Med) degree from the University of Cape Town, its highest degree and only awarded 11 times in over 100 years.

A pioneer in Women's Health issues and menopause research, in 1967 he established the Groote Schuur Menopause Research Clinic in Cape Town, the world's first such clinic. He was one of the three original founders of the International Menopause Society in 1976, of which he is Honorary Past President, and founded the North American Menopause Society in 1989.

He is the recipient of numerous national and international awards and research grants, and is still an active investigator with multiple grants. Dr. Utian has written over 200 papers related to the reproductive system in women and has authored five books on menopause and its effects on women. He is editor of *Menopause: The Journal of The North American Menopause Society*.

Do You Deserve your Patients' Trust?

An op-ed article in *The New York Times* last year grabbed my attention. "Do Patients Trust Doctors Too Much?" asked Pauline Chen, MD.¹ She had been intrigued by her review of Angie's List, a Web site best known for its user-generated report cards on local contractors. Reviewers to the site grade plumbers, roofers, dry cleaners—indeed, all types of businesses—using a generic report card. Doctors had been added to the list. They are all graded in five categories: price, quality of service, responsiveness, punctuality and professionalism. Then, there is a bottom-line question: Would you hire [this person] again?

The review process triggered my distant memory of a comment that has always stayed with me. That comment, which was made to my graduating medical school class by the graduation speaker, was as follows: "Always remember the three As of successful medical practice. They are Availability, Affability and, lastly, unfortunately, Ability!"

What Chen discovered in her review of Angie's List should therefore come as no surprise. To the reviewers in Angie's list the physicians who seemed rushed, brusque or distracted got poor or failing grades. The affable, warm, concerned and focused doctors got As or Bs. She found virtually no mention of a doctor's actual medical skill; ability, the final A of successful practice, really does come last!

The American College of Surgeons did a survey in which they found patients devote less than an hour researching a surgeon. Surely they spend at least 8 hours researching a new car.

The bottom line is that patients still place an extraordinary amount of trust in their doctors. In essence, it seems that if we graduated, completed a residency and passed our boards we are all alike. One surgeon will operate like another; all physicians will equally deliver the best of current practice.

Do You Merit this Trust?

But is this belief true and will it remain so? Do

we truly deserve to be trusted? The years 2008 and 2009 have, perhaps, been most remarkable for the exposure of **high-profile** individuals in the world of business, finance and politics who have defrauded, lied, abused, stolen **from** or betrayed their constituencies. Are we, in the health professions, better than that?

Health Professions Need some Soul Searching

Perhaps for the first time our health system is really coming under serious scrutiny, and the health providers are in the firing line. Cracks are already appearing—marked discrepancies in utilization and cost of the same procedures in different practice groups or geographic regions, inexplicable spreads in **ranges** of outcomes, bad apples being exposed for major degrees of Medicaid and Medicare fraud, falsification of research data by well-respected names, failure to disclose major conflicts of interest, and so forth.

The United States of America offers the most expensive health care per capita of any country in the world, and provides, on average, mediocre outcomes. We spend 50% more per person per

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year than the next most expensive country, and yet, on international health comparators, are invariably only in the double-digit zone of best-providing countries.

There are many components to the high costs of health delivery, but we on the provider side are certainly a key contributor. Firstly, there are the honest excesses of inefficient practice management. Just for a moment, consider the cost-effectiveness of your own daily patterns of practice. Are you utilizing modern business systems? Is your staff appropriately trained? Do you spend time on activities that could be provided less expensively by a trained assistant? Is there waste with regard to disposable products?—and so on and so on. A cost-efficiency analysis would certainly be worth while and potentially rewarding.

Secondly (and the thrust of my current editorial), there are the potential and actual dishonest activities that will come under close scrutiny. The activities under this category can be considered through overuse, underuse or abuse of screening tests and/or treatment interventions including pharmaceutical agents and procedures.

Think about overuse and potential abuse—sometimes difficult to differentiate. Do you recommend routine tests that are really unnecessary? Do you have expensive equipment on lease which, in anticipation of being a “profit center” to your practice, drives you to recommend its use to patients when clearly not indicated? Excessive use of bone densitometry equipment comes to mind here, but there are other obvious examples. Do you have self-interest at heart when you prescribe certain medications? I have written in the past about the abuse of so-called bioidentical hormones from the health-risk point of **view**. But unsubstantiated safety claims are being used to advertise services via the Web, for example, and drive unsuspecting women into excessively expensive consultations and prescriptions of compounded concoctions that invariably are more expensive and less likely to be reimbursed. This does not even address the conflict of interest when a “royalty” is paid for prescribing or the prescriber has a personal piece of the ownership of the compounding pharmacy itself. Does the level of reimbursement drive your decision as to what medical therapy or surgical procedure to recommend? For example, consider the variation in hysterectomy rates in different regions and different practices. Contemporary insurance data and other data bases are making it patently obvious that a surgical procedure is often undertaken when a medical prescription might have sufficed. A good example is perimenopausal menorrhagia with **an** hormonal etiology. How many unnecessary hysterectomies or endometrial ablations are undertaken when a prescription for an oral contraceptive or progestogen would have been perfectly adequate? These are just a few examples amongst many.

I have always believed that errors of commission, as illustrated above, are worse than errors of omission. But now I am not so sure when I ask you to think of underuse. How many opportunities are

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lost during office visits by failing to undertake necessary and indicated screening tests? There are abundant data on failure to perform Pap tests, or order mammography, screen for colon cancer and so on, resulting in expression at a later date of preventable disease. Underuse also can be applied to recording, interpretation and communication to the patient of results of tests that were actually performed. Almost 10% of abnormal test results are never communicated to patients. What a waste of resources and dereliction of responsibility!

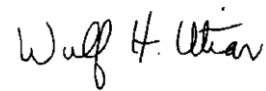
The Real Bottom Line

I challenge you to review all aspects of your current clinical practice—both the business and the professional sides.

For our part, NAMS will continue to provide to you through our various avenues the best recommendations for menopause and older women's health management during this demanding time in the his-

tory of medical practice. Be assured that “big brother” is watching. If we do not control our own activities we will bring down on our heads regulations that, in themselves, may bring unanticipated results that will not always be favorable to women's wellness or to the joy and comfort of medical practice.

It is unlikely that we will see an immediate change in the order of the three As of successful practice, but availability of provider-related service and outcome information through the **Inter-net** is expanding and accelerating rapidly, with regulation close on its heels, and the time is coming when Ability will come first.



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Reference

1. Chen PW. Do patients trust doctors too much? *The New York Times* 2008; Dec 19. Available at: <http://www.nytimes.com/2008/12/19/health/18chen.html?scp=26&sq=pauline%20chen&st=cse>. (Accessed July 15, 2009.)



ANNOUNCEMENT OF RETIREMENT: Pamela P. Boggs, MBA, Director of Education and Development

From its very inception, The North American Menopause Society has been all about people. The community we serve and the membership are our focus. To achieve what we do requires an extraordinary degree of effort and dedication from the members of the Board, the volunteers on the multiple committees, the Society members and, above all, a hard working, devoted and loyal Central Office staff. Few exemplify these characteristics better than Pam Boggs. She was the first full-time employee at NAMS (Carolyn Develen was the first employee, but was part time for the first several years), and has worked tirelessly and enthusiastically for 15 years. Much of what NAMS is today bears her imprint.

Menopause Management was Pam's idea; she was its original publisher/owner and, from the outset in the fall of 1988, I have been the Editor-in-Chief. She was also one of the original Founding Members of NAMS.

It is, therefore, with considerable regret that we have accepted Pam's intention to retire from NAMS as of December 1, 2009. While she certainly deserves time to smell the roses, we will be that much poorer by her absence. I do not believe there is anyone in the organization who has not learned something from Pam. In that spirit, she is going out as dynamically as she came in, transferring her knowledge and skills to many of the Central Office staff. Their future success, and the success of NAMS, will be Pam's legacy to the **organization**.

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NAMS Executive Director