SECOND OPINIONS

Lawsuit reprint ‘disappointing’

We were surprised and disappointed to see the reprinted Chicago Tribune article (June, AAP News) regarding Dr. Self’s lawsuit against our medical group. This article represented a very biased view and contained much inaccurate information.

At the time this article originally appeared in the Chicago Tribune (April 26, 1998), the jury in our case had not, as yet, completed its deliberations on the potential punitive damage claim, and the medical group and our counsel were therefore unable to publicly comment on the case. Since the settlement of this case, we have made ourselves routinely available to members of the media in order to respond to many of the inaccuracies that are being published about this case.

We were shocked and very disappointed with the jury’s verdict, and we strongly disagree with their findings. The case ended up settling, not because we were not confident we could prevail upon appeal, but because the medical group could not afford the disruption to its practice, and the lengthy and expensive appeal process, which could take up to three years and result in substantial additional exposure and costs for attorneys’ fees and appeals bonds, much of which is not covered by insurance.

Despite Dr. Self’s claims of fighting back against managed care, Dr. Self did not sue an HMO or an insurance company. He instead pursued Children’s Hospital and its 77-physician specialty group, both in the courtroom and in the press. The doctors in our group are all AAP members and have an unblemished record of 20 years of child health advocacy, as does Children’s Hospital.

While the article clearly expresses the view that Dr. Self’s contract was not renewed because of disputes with managed care, the fact of the record at trial indicated that many, many months before the decision was made not to renew Dr. Self’s contract, he was presented by the Board of Directors of the group with a number of concerns, including the fact that he had actively negotiated with a direct competitor of the group to take the entire GI division to a competitor. None of the issues raised by the group with Dr. Self had anything to do with managed care, quality of care or patient advocacy.

We are fully aware that Dr. Self was successful in persuading this particular San Diego jury that he had been unfairly treated by the group. There was a clear effort to inject the “managed care” issue into the case, given the public’s misgivings and concerns about managed care, to turn what was otherwise a contractual dispute into something that it never was in reality.

What we find so disappointing is that the AAP News would reprint the Chicago Tribune story without any independent confirmation of its accuracy or any attempt to contact us and obtain our view about the facts of the case or the facts set forth in Ms. Brandon’s article.

I.A. Kaufman, M.D., FAAP
San Diego, Calif.

Better uses for AMA’s $20 million?

I am writing to comment on the AMA Accreditation Plan as reported in the July AAP News. It is inappropriate for an organization such as AMA to become involved in this activity. Furthermore, I do not perceive a need for this type of “credentialing.”

The AMA should not appear to the AMA leadership that it not only will not support this endeavor but will actively oppose it. Certainly the AMA can find a better way to invest $20 million.

David Cimino, M.D., FAAP
St. Petersburg, Fla.

Capitation data laughable

I read Dr. Corrigan’s article about “Capitation’s Cheap Trick” (July, AAP News) with particular glee. I feel that capitation gives one an incentive not to see a child whether sick or well.

Mason B. Gomberg, M.D., FAAP
White Plains, N.Y.

During our negotiations with U.S. Healthcare last year, we asked repeatedly as to how they came to their capitated rates. We wanted to know how many visits per year they allotted for each age group. Since many of our Aetna patients were being shifted into U.S. Healthcare, we had a very good idea about their health usage patterns.

Six months later we almost laughed at the data provided by U.S. Healthcare. They believed that during the first five years of life, a baby or child in the New York metropolitan area would be seen as follows:

<table>
<thead>
<tr>
<th>Age</th>
<th>Visits Per Year</th>
</tr>
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<tbody>
<tr>
<td>0-1</td>
<td>8.36</td>
</tr>
<tr>
<td>1-2</td>
<td>5.32</td>
</tr>
<tr>
<td>2-3</td>
<td>3.24</td>
</tr>
<tr>
<td>3-4</td>
<td>2.91</td>
</tr>
<tr>
<td>4-5</td>
<td>3.08</td>
</tr>
</tbody>
</table>

These data include both well care and sick visits! Any pediatrician or mother would be quick to point out that a 2-3 or 4-year-old has a high probability of being ill and brought to their pediatrician more than three times a year.

Under this scenario, HMOs will foster a two-tier system. Those who are capitated may find it difficult to be seen whether they are well or ill, vs. others who have easier access to their health care provider. Unfortunately, my patients do not understand their health care options, nor the incentives HMOs have in their various health care products.