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SSRIs

Your article on the controversy surrounding selective serotonin reuptake inhibitors (SSRIs)[1] is very much appreciated by many people.

SSRI Stories now contains 628 murder incidents, counting school shootings and workplace violence, and more than 200 murder-suicides. Even if the violence cannot be proven to result from the antidepressant, there is at least evidence that in these particular cases, the SSRI did not make the perpetrators calmer, more relaxed, or happier people.

Dr. Kauffman's article was thorough and scientific. The bibliography was impressive. Thank you for publishing it.

Rosie Meysenburg
Moderator: www.SSRIstories.com

I want to applaud the *Journal* for having the courage to publish the article on SSRI drugs. Dr. Kauffman did an excellent job of detailing the facts.[1]

Having spent approximately two decades gathering information on SSRI-related problems so that journalists would be encouraged to ask the right questions, it is gratifying to see a medical journal finally address this issue.

Physicians need to be aware of the serious adverse reactions associated with SSRI use. Dr. Kauffman's article will serve to heighten this awareness to the benefit of patients everywhere.

Ann Blake Tracy, Ph.D.
Executive Director, International Coalition for Drug Awareness

[1] Kauffman JM. Selective serotonin reuptake inhibitor (SSRI) drugs: more risks than benefits? *J Am Phys Surg* 2009;14:7-12.

Judging the Quality of Medical Care

In his commentary, "Organization on High: Expanding Use of Physician Examination Scores," the late Dr. Hilton Terrell cited the abuse of "evidence-based guidelines" such as mammography screening rate, contraindicated prescribing rate, referral rate, and disease-specific symptom relief as indicators of quality care.[1]

As Terrell aptly pointed out, this abuse stems from the erroneous concept that economic resources and quality care proclamations are the domain of "Rulers on High" who serve the collective rather than individual patients.

Despite proclamations by "Rulers on High," the free market is well suited to deal with the issue of quality care. In a free market, patients are the ultimate judge of the quality and type of care they wish to receive. Physicians in a free market are rewarded, not by speculations based on physician examination scores, but by actual care delivered.

The direct-payment model, whereby patients use their own resources, including health savings account (HSA)/high deductible health plans, is the only model that assures that the physician will be directly accountable for the quality of care rendered to the patient.

Howard Long, M.D., M.P.H.
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[1] Terrell HP. Organization on high: expanding use of physician examination scores. *J Am Phys Surg* 2009;14:13-16.

Certification and Re-certification

As I have gotten older and, I hope, wiser, I have developed the perception that board certification is a self-serving procedure. Most physicians become board certified right out of training, when they have lots of book knowledge but not a lot of experience. There are many factors that make a great clinician besides passing a board exam. I think that the current system's focus on board certification is actually a cop-out. The authorities in charge

can point to the examination certificate and say, "No worries; we've done our part," when an effective evaluation for competency is too difficult, expensive, or politically incorrect to do. Licensure board newsletters also report dozens of board-certified physicians being delicensed, disciplined, or subjected to stipulations every quarter.

It gives me great encouragement to learn that other physicians have been concerned about the true implications of board certification or recertification.

Jeffrey C. Pitts, M.D.
Ontario, Ore.

Recertification[1] is arguably an impediment to physician livelihoods, not a clear inducement to safe and effective medical practice. To illustrate, consider these excepts from the website of the American Board of Physical Medicine and Rehabilitation (www.aapmr.org) and links within that site.

"Diplomates ... are required to complete ... a minimum of one practice performance [sic] *project [every ten years]."*

It seems reasonable to require knowledge per impartially administered test, and in fact the AAPMR does administer such a test (see below). But a practice performance project is not so easily shown to verify clinical competence.

What is a practice improvement project? I found only one reference to a practice performance project on the website. It requires deciding on non-subjective, measurable potential improvements in patient care and documenting step-by-step progress toward achieving those improvements.

No one is perfect; improvement is always theoretically possible. But such a requirement for recertification will encourage careful board-certified physiatrists to damage various components of their practice so as to have easily improvable criteria while the specialty-board reviewers are watching. We wish all physicians, board-certified or not, would try hard and make their patient care as good as possible; but by doing so they make further improvement very difficult indeed.

Laws protect endangered species, restricting land from development when various animals show up on the land. These laws induce landowners to cut down forests and otherwise destroy wildlife habitat for fear of losing rights to their land, and thereby drive out the endangered species and indirectly endanger them further. This observable effect is predictable with ordinary intelligence, and is observed.[2] The effect of mandating improvements has a similar consequence, which is harder to assess because the criteria by which a crafty physiatrist weakens a practice can be contrived to be unmeasurable without permission.

"All ... (ABPMR) certification exams [are] confidential."

Protecting the integrity of the examination process is understandable. Not so for the absence of sample questions, preferred answers, and the scoring of right and various wrong answers. As there is little guidance as to what to study, it is possible for a bright applicant to study clinically relevant material not covered by the examination, and fail despite above-average clinical skill. Because a clear identification of the knowledge base being tested is generally unknown, skeptical outsiders will ask, more and more often, what it means to be board certified. And with rational debate about statins, vaccines, and other issues becoming common, the specialty boards will have to announce their position on such controversies, and not merely use self-referencing proclamations of expertise. Moreover, answers to any questions, relevant or not, or the existence of irrelevant or even absurd questions, cannot be challenged when secrecy precludes revealing or denying that a certain question has a certain answer on the test.

For example, even a statement as egregious as the following could stand unchallenged: "Q: What is the preferred treatment for an actively bleeding scalp wound? A: Apply a tourniquet to the patient's neck."

"Specialty-specific CME: A minimum of 50% of the 500 total CME credits [during the ten-year period preceding recertification] must be related to the specialty of physical medicine and rehabilitation and/or its subspecialties."

Requiring at least 250 continuing medical education credits in the specialty, and at least 500 CME credits total, is one thing. Insisting that at least half of all CME credits are in one's specialty is something else again. What of the physician board certified in two specialties, each insisting on 50 percent of the CME credits, who has to take a specified non-specialty CME-granting course as a condition of maintaining a physician license?

Certification examinations in which there is a percentile cutoff (the lowest 10%, 25%, or whatever fail, while everyone else passes) are not defensible if one wants to assure good clinical competence. What constitutes adequate knowledge has nothing to do with what happens to be known by the majority of people taking a test alleged to assess such knowledge. If the people who set the criteria for passing were honest, then they would risk widespread failures if most people learned poorly, and would welcome a 100% pass rate if everyone learned superbly. The pass-fail cutoff would not have anything to do with the raw scores of those who take the test.

Finally, there is no recertification requirement for physicians who are not board certified or who do not bother renewing their board certification. To protect the citizenry, one would perhaps expect a protocol for retesting all licensed physicians every 10 years, with such testing being offered as part of a specialty board recertification examination. A physician might take such a test and be told, "Yes, you are knowledgeable enough in basic clinical skill to keep your license, but no, we will not certify you in this specialty." Is it possible that specialists and subspecialists no longer have the basic competence that recent medical school graduates take for granted, and do not want that fact exposed?

HIPAA, which might be called the Help Increase Paperwork Activity Act, demands a compliance officer and various other paperwork activities and personnel. So can practice improvement projects. The government could reduce unemployment–temporarily–by mandating numerous make-work tasks requiring additional employees, until the employers so afflicted go out of business. The Soviet Union boasted a low unemployment rate–until the union disunited. Will sickening trends in our nation's health policies make the "United" States go under next?

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[1] Orient JM. Physicians skeptical of recertification. *J Am Phys Surg* 2009;14:17-18.
[2] Murray I. *The Really Inconvenient Truths*. Regnery; 2008:239-242.