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TO THE EDITOR:

We are writing in response to the article "Differences in Costs of Treatment for Foot Problems Between Podiatrists and Orthopedic Surgeons."¹

Although we are pleased that a study was done to determine the differences of treatment for foot problems between podiatrists and orthopedic surgeons, we are concerned that the failure to measure the quality of care renders the study too flawed to provide an adequate analysis of the differences. Quality of care issues not analyzed include the following: length of time before returning to full recovery, percent of remaining disability at recovery, and patient satisfaction ratings.

There are additional questions about the methodology and approach of this study that are not fully answered by the article itself. Specifically, the article does not indicate whether the charges used to compare podiatrists and orthopedists are billed charges or actual payments. Since there can be significant differences between what a provider charges and what is paid, the conclusions reached by relying on charge data may be misleading. It is possible that podiatrists are paid significantly less than their billed charges.

In the comparison of mean charges for professional services for the treatment of acquired toe deformity and bunions, the analysis does not reflect the cost of inpatient hospital services that would likely affect the comparison of total costs between podiatrists and orthopedists for these conditions. The article reports significantly higher hospital use for the treatment of both of these conditions by orthopedists—8.5% vs. 4.4% in the case of acquired toe deformity and 12.4% vs. 5.7% for bunions.

In presenting the data on the number of procedures per episode of care, the authors do not discuss a potential explanation of the observed differences that we believe casts a very different interpretation on the study's findings. That is, podiatrists in the course of their treatment of the patient's presenting complaint frequently diagnose other conditions that require treatment. In short, rather than assuming that podiatrists are providing more procedures for the same diagnosis than orthopedists, the observed differences may result from the treatment of other conditions related to the primary diagnosis. Vied from this perspective, the comparisons could suffer from an "apples and oranges" problem. Some of the codes included in Table 2 describe procedures that may be used for a range of conditions other than acquired toe deformities and bunions.

Finally, as acknowledged by the authors, the study does not report data on the outcome of patients treated for similar conditions by different specialists, nor does it evaluate the medical necessity or appropriateness of the care provided. We believe these are essential components of any comparison without which the results are subject to a

substantial risk of error or misinterpretation or both. Given the paucity of empirical study of practice by different specialists for the same or similar conditions and the limitations of the existent studies, we are disappointed that the authors did not acknowledge more fully the study's limitations and call for more research on these important questions.

We are disturbed that the authors would recommend strong utilization controls that reduce referrals to podiatric physicians or capitation arrangements independent of actual utilization. It seems to us that these recommendations, made without analyzing quality of care issues and the additional questions about the methodology and approach of this study, are contrary to the healthcare needs of the public. The study clearly points out that podiatric physicians are the major providers of foot care because of the cost effectiveness and quality of service provided.

As providers of most professional foot care services to millions of Americans, we are deeply concerned about the implications of this study. We do not believe the data available support the conclusions and policy recommendations of the authors.

Marc D. Lenet, DPM
President

American Podiatric Medical Association

I. Harris RB, Harris JM, Jr, Hultman JA, Weingarten, S. Differences in costs of treatment for foot problems between podiatrists and orthopedic surgeons. *Am J Man Care* 1997;3:1577-1583.

AUTHORS' REPLY:

We thank Dr. Lenet for his letter regarding our study. He is concerned that our study focused on differences in the costs of caring for patients with foot problems rather than focusing on quality of care. He maintains that not including these components renders the study too flawed to provide an adequate analysis of differences.

We agree that it would have been desirable to study quality of care and patient outcomes, in addition to cost of care. However, when the California Podiatric Medical Association funded this research study, there was insufficient funding available to perform a rigorous study of patient outcomes. We decided to initially focus on differences in utilization and charges between orthopedic surgeons and podiatrists (in order to confirm the earlier 1987 report¹) and to later investigate quality and outcome differences as part

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of a follow-up study. The hypothesis of the present study² (funded by organized podiatric medicine) was that podiatrists were less costly than orthopedic surgeons in caring for patients with similar foot problems. As Dr. Lenet points out, our study failed to confirm this hypothesis.

Dr. Lenet asserts that podiatric physicians are the major providers of foot care because of the cost-effectiveness and quality of service provided. We would encourage the American Podiatric Medical Association to take a leadership role in validating this assertion through scientific investigation. In the absence of rigorously derived research data, we cannot have an informed and scholarly debate on differences in quality of care between the different providers of foot care.

Dr. Lenet expressed some concern with the methodology of this study and was uncertain if the charges used were billed charges or actual payments. Billed charges were used because the insurance plan we studied, as most insurance plans, could not provide data on payment on specific claim items, making it impossible to evaluate the reimbursement for individual services. We continue to believe that the charges submitted by podiatrists and orthopedists for their services, as reported in this paper and elsewhere, remain a useful measure of services performed and expected levels of reimbursement.

We do not advocate imposing utilization controls in the absence of rigorously derived quality of care or outcomes data demonstrating that a particular provider provides superior care. We do strongly recommend that analyses of costs of care be conducted by examining episodes of care, as was the case in our study. There is a pressing need for more high quality research studies examining quality, cost, and value of care for patients with foot problems.

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1. Weiner JP, Steinwachs DM, Frank RG, Schwartz KJ. Elective foot surgery: Relative roles of doctors of podiatric medicine and orthopedic surgeons. *Am J Public Health* 1987;77:987-992.
2. Harris RB, Harris Jr JM, Hultman J, Weingarten S. Differences in costs and treatment for foot problems between podiatrists and orthopedic surgeons. *Am J Man Care* 1997;3:1577-1583.

Dr. Lenet's response raises several good points. I agree that in the absence of outcome data, no definitive conclusion can be drawn regarding the need for "strong controls to offset higher utilization." This opinion is not supported by scientific data and implies that it is desirable to reduce utilization for specialty services, regardless of the effect on patient outcomes.

The data in this study are consistent with what would be *expected* when comparing services of generalists to those of specialists. Orthopedists are generalists in that they are licensed to diagnose and treat any bone and joint problem. Podiatrists, on the other hand, are specialists. One would reasonably anticipate, therefore, that the study would find not only that podiatrists treat the majority of foot problems but that they also perform more procedures per episode of care. Similarly, consider dental care. I would expect a study to show that patients experiencing tooth pain would receive substantially more procedures per episode of care and would be treated for a longer time when being treated by a dentist than when seeing an internist. In the absence of outcome studies, this data would not suggest the need for strong utilization controls for dentists any more than the data presented in this study would for podiatrists.

While claims data is a useful first cut for obtaining utilization data, future studies should focus on determining which specialty services lead to better outcomes and whether the benefit of these additional services is worth the cost.

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Instructions for Letters to the Editor.*