method of reimbursement in September 1993, not because of disenrollment.

In the “Comment” section of our article, we indicated that one limitation of our study was our inability to track patients who moved between the 2 settings. We agree that patients with chronic medical problems tend to stay with physicians with whom they have developed a long-term relationship. Nevertheless, given the ease with which Medicare patients can move between health care settings, we are not as convinced as Dahl that patients with visual problems would stay in any one setting if they felt they were not getting a needed cataract extraction. In addition, there are many reasons why Medicare patients might choose to belong to an HMO, including drug benefit plans, vision plans, and smaller co-payments. These incentives may be enough to pull a patient away from a relationship with an FFS ophthalmologist, particularly if there was no current indication of a need for vision care. How this potential movement of patients between settings could affect the rates of cataract extraction is uncertain.

As indicated by Mr Peterson and Mr Silberman, our findings are important because they highlight a potential quality-of-care problem that must be studied. We agree with them and with Dr Prager and colleagues that such a study requires an assessment of visual functioning as it relates to cataracts. We believe it is crucial not only to detect cataracts when they exist but also to evaluate their significance in terms of their impact on a given patient’s ability to perform his or her usual activities.

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In Reply.—Dr Kliger’s letter raises several valid points that might influence the behaviors of practitioners working in prepaid or FFS settings. The processes involved in clinical decision making in all fields of medicine are guided by the knowledge, skill, and experience of the physician or surgeon. Yet, despite the proficiency of the practitioner, he or she needs to base clinical decisions on current thinking in a particular area of interest. The American Academy of Ophthalmology’s Preferred Practice Patterns (PPPs)3 were initially introduced in the late 1980s and have undergone review approximately every 3 years. These are evidence-based documents that rely on consensus opinion of a group of experts when evidence is lacking on a particular point.

The PPP “Cataract in the Adult Eye”1 was written by a group that was composed of ophthalmologists, an internist, a methodologist, and a patient representative. The document is intended to serve as a clinical guide for contemporary cataract surgery and is linked to outcome measures. The key issue in any payment setting is the appropriate care of patients with a cataract. As Kliger states, “financial incentives can be very powerful” as influences in the determination to perform, withhold, or delay cataract surgery. However, the application of the recommendations of the PPP speak for appropriate care.

An essential issue raised in my Editorial is the need to assess the effect of withholding or postponing cataract surgery on the well-being and functional activity of the beneficiary population. Although published studies have acknowledged the benefits of cataract surgery, there is a paucity of information regarding the consequences of deferring this procedure. It is unlikely that such a study will be performed because the benefits of cataract surgery are so compelling. If the differences between the prepaid and the FFS settings were minimal, I would agree that my major concern would be with only the “marginal” cases. However, the dramatic disparity in the rates between the 2 groups suggests that factors other than those that reflect the functional needs of patients are dominant.

If clinicians are guided by evidence-based practice guidelines, involve the patient in the decision-making process, and consider what is in the patient’s best interest, appropriate care will be provided independent of the method of payment. Well-constructed practice guidelines lessen the variability in modes of practice. Adherence to the principles of these guidelines should also minimize the variability in rates of cataract surgery by insurance status.

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The National Council on Patient Information and Education

To the Editor.—In the Medical News & Perspectives article by Mr Marwick,1 Ray Bullman, executive director of the National Council on Patient Information and Education (NCPIE), was reported to have said that a coalition has been organized to implement the Action Plan for the Provision of Useful Prescription Medicine Information (MedGuide) and that all 34 original steering committee organizations responsible for drafting the plan have joined. If these statements have been correctly attributed to Mr Bullman, they are untrue. As public interest groups and members of the original steering committee responsible for drafting the MedGuide, the AIDS Treatment Data Network, Center for Medical Consumers, Citizen Advocacy Center, National Women’s Health Network, and Public Citizen have not joined NCPIE in the coalition alluded to by Mr Bullman.

We have refused to associate with the NCPIE implementation program for 2 reasons. First, we view NCPIE’s economic and philosophical juxtaposition to organizations long opposed to the distribution of useful written drug information to patients as not in the public interest. Second, in the 15 years since its inception, the programs and policies espoused by NCPIE have failed to provide patients with useful drug information. Testaments to this failure were the need for a congresionally mandated process that created the MedGuide, the selection by the Department of Health and Human Services (DHHS) of the Keystone Center—not NCPIE—to facilitate development of the MedGuide, and the exclusion of NCPIE from any formal role in the MedGuide.

How to implement and evaluate implementation of the MedGuide was one of the most controversial issues faced by the steering committee. Agreement was not achieved, and DHHS Secretary Donna E. Shalala was presented with 2 very different options on implementation of the MedGuide. Public interest groups favored strong oversight and enforcement by the Food and Drug Administration (FDA). Groups representing the health care industry endorsed a small “transition group” of the private sector that consisted of steering committee members. Creation of a transition group from the original steering committee to oversee the implementation process was unacceptable to the undersigned public interest groups. Of the 34 organizations constituting the steering committee, 12 are represented on NCPIE’s board of directors. This, in fact, would have reconstituted a smaller version of NCPIE, which we view as a failed paradigm.

Secretary Shalala chose neither option; rather, implementation was left to the organizations participating on the steering committee, with the DHHS having authority to determine if the congresionally mandated distribution and quality goals are met by 2000. The DHHS has delegated its authority over imple-