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LETTER FROM AMERICA

Mohs vs. Madison

Recently I attended a conference for continuing medical education credit where the speaker was an internationally recognized expert, editor and author who lectured on his specialties of Mohs micrographic surgery and lasers. To satisfy the Accreditation Council for Graduate Medical Education (ACGME), the governing authority that awards continuing medical education franchises, each conference's announcements must disclose what commercial interests are funding that conference and must disclose what relevant financial relationships with commercial interests both the conference's organizers and speakers have. For example, if a conference will be concerning complications of facial fractures, then both the conference's organizer and invited speaker must disclose if they are consultants for or stockholders in manufacturers of any relevant surgical device.

In compliance with the ACGME requirements, the speaker began his presentation with a detailed description of his financial relationships with the publishers of the various books and journals that he has edited that pertained to his topics.

Bud Menn – the 1970's

As the presentation got underway, I fondly recalled prior presentations by the late Henry W. (Bud) Menn who was the first full-time university based Mohs specialist in Florida. Bud had warm relations with the plastic surgery community. He had little interest in treating routine primary basal cell carcinomas (BCC) and no interest in attempting any reconstruction. Gary Burget became interested in nasal reconstruction when he was a resident under Millard. When Gary completed his residency, he entered practice with Walter Garst, who had left Millard's office after having been his associate for five years. Millard was not pleased. He was even less pleased when he learned that Bud started sending some of his most complex Mohs defects to Gary for reconstruction. When Gary elected to return to Chicago, his hometown, Bud continued to support him by recommending him to the Chicago Mohs specialists. Bud aided other plastic surgeons as well. He was the first physician to refer a patient to me when I started my practice. It still makes me chuckle to remember how, a couple of months later, I opened my office mail and spent some time staring at an invoice from a vendor whose name I did not recognize. Only slowly did it dawn on me that it was not an invoice, but a check – the first check that I had ever received from an insurance company. It was payment for my evaluation of Bud's patient.

Mohs – 2012

These events occurred more than a quarter of a century ago, but what of today? What does a Mohs specialist tell a group of sophisticated plastic surgeons in 2012? The conference's official announcement claimed that the presentation's objective would be to "Analyze Mohs Micrographic Surgery". Did the speaker meet the stated objective? Did he analyze the latest in evidence based medicine, meta-analysis, systematic reviews and randomized control trials?

No. It was dollar driven. The focus was on what "insurance companies" considered indications for performing Mohs. When the time came for questions, I patiently awaited my turn. Another participant asked if there were any randomized control trials comparing Mohs to other forms of treatment. He said that there were none. When it was my turn to question him, I thanked him for beginning his presentation by disclosing his financial relationships.[a] I reminded the audience that the highest quality clinical research involved blinding in order to eliminate bias. I then asked him if Mohs treatment would not be better if one person did the excision and another read the slides to eliminate bias. He said that he was not biased. Next, I asked him about the feasibility of a two member team approach for other Mohs specialists who, unlike him, might

[a] Only later in the day did I learn that he had failed to disclose his financial relationships with Genentech and LAVIV, both biotechnology companies.

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be biased. He said that he did not think that would be feasible as insurance companies only pay for a single Mohs specialist's services. I suggested that at teaching institutions with residents and fellows that there was ample opportunity to use trainees in these roles as the teaching institutions are not allowed to submit bills for the trainees. He was unmoved. What was most distressing to me was the speaker's rigidity and refusal to admit that he might be biased, particularly as he should have been familiar with the concept of bias from his having served in editorial positions of scholarly journals.

Can it work, does it work, is it worth it?[1]

This was the title of a BMJ editorial on the questions that should be asked about any healthcare intervention. The answers to these three questions are what I had hoped to learn from our visiting professor rather than a series of show and tell images of various and sundry defects that he had left in his wake.

Here is what I have learned in the past few days since deciding to write this letter. There is a dearth of studies on Mohs that would withstand the rigorous standards of evidence-based medicine. I could find but one systematic review in PubMed. It reviewed all available studies of BCC from 1990 to 1997 yet only identified 18 studies with at least 50 patients followed for five years who had been treated with Mohs, surgical excision, curettage and electrodessication, cryotherapy, radiation, immunotherapy, or photodynamic therapy. The reviewers concluded, "Recurrence rates for different therapies could not be compared because of a lack of uniformity in the method of reporting, so evidence-based guidelines could not be developed".[2] In 2007, a Cochrane Group attempted to assess the effects of treatment for basal cell carcinoma. Despite what our visiting professor stated, the Cochrane researchers did discover a single randomized control trial that compared Mohs to surgical excision.[3] That trial followed patients for 30 months and found no statistically significant difference in recurrence rates for either the primary or recurrent basal cell carcinomas treated by either Mohs or surgery.[4] The trial continued for 60 months. For primary BCC there was no statistically significant difference in recurrence rates between Mohs or surgery, but Mohs was statistically significantly better than surgery for recurrent BCC. A cost analysis suggested that Mohs was definitely not cost effective for treating primary BCC and may have been less cost effective than surgery even for treating recurrent BCC.[5]

Mohs vs. Madison

By now you may have an inkling as to why this essay is called Mohs vs. Madison. The Madison in question is James Madison, fourth President of the United States, father of the US Constitution, who formulated our system of government. He wrote a series of essays collected in a book called *The Federalist Papers*. Madison explained the need for, what he called "checks and balances" and "separation of powers" that he noted were needed in both public and private interactions. He wrote:

> "This policy of supplying, by opposite and rival interests, the defect of better motives, might be traced through the whole system of human affairs, private as well as public. We see it particularly displayed in all the subordinate distributions of power, where the constant aim is to divide and arrange the several offices in such a manner as that each may be a check on the other."[6]

Abuse of the powers to diagnose and treat

As I wrote in my last Letter from America, when it comes to bizarre medical stories, Florida has pride of place.[7] In answering the question "Was it worth it", consider the tale of fellow Floridian, Mr. Michael Rosin. Until 2006, he was known as Dr. Michael Rosin as he had held a license to practice medicine in Florida. He was a Mohs specialist who performed thousands of operations on elderly patients who were covered by Medicare, our federal insurance for the elderly and disabled. From September 1998 through May 2005, he performed 5980 skin biopsies with 99.43% being diagnosed by him as malignant, thereby necessitating 4118 Mohs procedures of which 98.93% required four stages. An investigation ensued after his office manager and a former patient filed a "whistle-blower" lawsuit on behalf of the US government. The government charged him with 35 counts of health care fraud and 35 counts of making false statements in a health matter. During a 17-day jury trial, it was proved that he had diagnosed cancer even on slides that contained no human tissue, but Styrofoam and chewing gum. The jury convicted him on all 70 counts and a judge ordered him to pay a $25,000 fine, make restitution of $3,697,225.38 and forfeit $3,697,225.38.[b,8] Rosin's appeal to the 11th US Circuit Court was unsuccessful. Compliments of the Federal Bureau of Prisons, he now resides at the Federal Correctional Institution, Miami. He will continue to live there, rent-free and free of conjugal visits, until September 4, 2025, when his 22-year sentence is scheduled to end.[9]

Gillies' lesson

Surgical bias has been known by generations of plastic surgeons. Gillies described how cancer patients were better treated by a separation of powers when he and Millard wrote "Cure First, Repair Second":

> "The destroyer should destroy, and no consideration of the deformity should stay his hand. Too often, the general surgeon will ask courteously whether sparing such and such a bit will make the repair easier. He is genuinely trying to help in the repair and forgetting his primary duty. The answer must be, "I couldn't care less. You remove the malignancy so it does not recur, whatever the deformity, and let me worry about the repair".[10]

[b] The government gave the former office manager and patient a $1 million reward for their assistance. See Martin ST. Two women share $1-million for exposing Sarasota doctor's fraud. Tampa Bay Times December 9, 2008. http://www.tampabay.com/news/courts/article930881.ece Accessed June 18, 2012.

WAME (pronounced whammy)

It might have behooved our dermatological editor to have been familiar with the World Association of Medical Editors (WAME) policy statement on conflicts-of-interests (COIs) as it is relevant not only to us as writers and editors, but also to us as physicians and surgeons:

> "Everyone has COIs of some sort. Having a competing interest does not, in itself, imply wrongdoing. However, it constitutes a problem when competing interests could unduly influence (or be reasonably seen to do so) one's responsibilities".[11]

How do we lessen the possibility being unduly influenced or biased? In evaluating clinical trials, we look for true randomization, blinding of the patients, if feasible, and blinding of the evaluators. If Mohs surgeons are going to continue to treat patients singlehandedly, then they must be prepared to prove to patients, peers and payors that they have a satisfactory mechanism for maximizing quality and value while minimizing waste and bias.

Financial disclosures

None.

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