LETTERS TO THE EDITOR

PUT PREVENTION INTO PRACTICE

To the Editor:

I am writing in response to the article by McVea et al titled "An Ounce of Prevention? Evaluation of the 'Put Prevention into Practice' Program[1] and the accompanying editorial by Stange.[2] The authors reported in the abstract that "PPIP materials are not being utilized, even by the clinics that ordered them," and the editorial quoted a peer reviewer as stating that this finding "puts the final nail in the coffin of the old paradigm" of approaches to improving clinical preventive service delivery.

The methodology of this study cannot support such a broad and definite conclusion. This was a qualitative study using a convenience sample of only eight practices from among over 2000 practices that have ordered PPIP materials from the American Academy of Family Physicians (AAFP). These same researchers have stated at professional meetings that they have undertaken a randomized national survey of these practices. Results from that survey, not the small qualitative study reported in the *Journal*, could address the issue of utilization of PPIP tools with some validity.

I assume that the "old paradigm" referred to in the editorial as dead is "one size fits all." Having worked on the development of the PPIP materials, I can tell you that this was not a paradigm PPIP staff ever embraced. A variety of different office system materials were developed out of knowledge that no one type could satisfy the needs of all practices. It was hoped that clinicians would find at least one type of tool in the kit that they could utilize in practice or employ as a model to create a similar tool to meet their practice needs. Initial evidence from other sources suggests that this goal may have been largely accomplished.

Another major area in which the PPIP program sought to avoid unidimensionality was in dissemination and implementation. AAFP chose to adopt a mail-order approach that is economical but provides little technical support. The Texas State Health Department chose to introduce the tools into clinic settings with the support of considerable staff training and involvement. The American Cancer Society (ACS) has promoted the PPIP program in private practices through visits by lay and professional volunteers. Several managed care organizations have encouraged providers to use the materials as a way to improve their HEDIS scores. Thus, a variety of interventions have been initiated, many of which have gone beyond dissemination of tools to directly address the process of practice change.

McVea and colleagues are to be commended for the detail with which they studied eight practices in the AAFP arm of the PPIP program. The typology of practices they have delineated may prove useful not only to the AAFP PPIP program but to others studying and confronting the complex barriers to preventive care delivery. I, too, am skeptical that simply mailing tools is sufficient to change most practices significantly. However, the authors of both the article and the editorial should be very careful not to conclude that these results can be generalized to other practices or to the PPIP program as a whole.

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1. McVea K, Crabtee BF, Medder JD, et al. An ounce of prevention? Evaluation of the 'Put Prevention into Practice' program. J Fam Pract 1996; 43:361-9.
2. Stange KC. One size doesn't fit all. Multimethod research yields new insight into interventions to increase prevention in family practice. J Fam Pract 1996; 43:358-60.

The preceding letter was referred to Drs McVea and Stange, who respond as follows:

In Reply:

Dr Dickey has raised some important issues in his response to our article. I would like to address these issues on behalf of all the paper's authors.

First let us clarify that in our paper we did not attempt to generalize our conclusions about the actual use of "Put Prevention into Practice" materials beyond the purposeful sample of eight practices actually studied. We acknowledged the limitations of this geographically restricted group of private practitioners and recognize the need for additional study of more diverse practice settings. Also, it was our intent to describe the use of PPIP materials distributed by the AAFP's mail-order process, not the effectiveness of other interventions using PPIP tools or other methods of dissemination.

PPIP materials were developed by researchers experienced in the area of prevention. Each component included in the PPIP kit had been individually validated. Based on the

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existing literature, its creators had every reason to believe that they would increase the delivery of clinical preventive services. We ourselves had initially been optimistic that the PPIP kit would be effective in the subset of practices we chose to study (practices that had ordered PPIP kits plus additional supplies). Unfortunately, even in this select group of practices, the PPIP materials were not used. This is a disappointing finding for all of us interested in promoting prevention. Our job as researchers and clinicians is now to figure out why PPIP was not implemented and to decide what to do next. The qualitative portion of our study allows us to offer some preliminary suggestions.

Dr Dickey points out that PPIP kit does offer a variety of clinical prevention tools to choose from, some of which can be modified by the individual practice. We were not disregarding this flexibility when we described the intervention as "one size fits all." Rather, we were referring to the fact that not all practices need *tools* in order to improve the delivery of preventive services. Some practices need skills in implementing tools and establishing office routine that facilitate preventive care. Other physicians and staff members may need training in order to develop clinical or counseling skills. Practices may need better support or incentives to motivate them to do certain types of preventive counseling.

Offering technical support for the implementation of PPIP materials, like that provided by the Texas Department of Health and American Cancer Society volunteers, is one approach that might make PPIP more effective. We advocated this in our paper. We ourselves are intervening in practices using PPIP materials, computer-generated reminder systems, and staff training. But even with this intensive, very individualized approach, effecting long-lasting change in practice operations is not always possible. This level of support is certainly not what most purchasers of the PPIP kit from AAFP received.

Our findings reflect less on the quality of the PPIP materials than on our limited understanding of how to change practice culture and routines. The next real research challenge is to unravel the complexities of the office system and determine how to collaborate with practices more appropriately.

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In Reply:

"PPIP is a state-of-the-art program."[1] When he was a Luther Terry Fellow at the Office of Disease Prevention and Health Promotion, Dr Dickey's work in developing and synthesizing these materials and shepherding them through multiple levels of approval by a wide variety of constituencies was vitally important in leading to the consensus materials that are now available. Updates and modifications currently under way at the Office of Disease Prevention and Health Promotion will further enhance PPIP's status as the reigning system of widely available office materials for enhancing delivery of a broad range of preventive services.

I agree with Dr Dickey that one study, especially one with a small sample, cannot refute or establish the utility of PPIP. However, since the selection biases involved in the study by McVea et al[2] are likely to favor enrollment of practices that had implemented PPIP, the study's findings about the difficulty in changing practice with a mailed set of materials are not easily dismissed. Moreover, the editorial attempts to put the study by McVea et al into the context of a larger body of evidence that points to the need to individualize approaches to altering practice behavior. As Dr Dickey points out, this is not necessarily a criticism of PPIP; practices can individualize their implementation by choosing which components to use and by adaptations or modifications of some of the materials. Office systems materials, such as PPIP, can be important components of efforts to individualize practice change efforts.[3]

The efforts of the Office of Disease Prevention and Health Promotion, the American Academy of Family Physicians, the American Cancer Society, managed care organizations, and others to disseminate PPIP are laudable. We must realize, however, that by themselves, such efforts will be insufficient to raise clinical preventive services delivery to desired levels. Additional tailored efforts are needed that are based on a grounded understanding of the strengths, limitations, and variability of real-world practice.[3]

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1. Stange KC. One size doesn't fit all. Multimethod research yields new insights into interventions to increase prevention in family practice. J Fam Pract 1996; 43:358-60.
2. McVea K, Crabtree BF, Medder JD, et al. An ounce of prevention? Evaluation of the 'Put Prevention into Practice' program. J Fam Pract 1996; 43:361-9.
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OBSTETRIC LIABILITY INSURANCE

To the Editor:

I read with disbelief the article titled "Charges for Obstetric

Liability Insurance and Discontinuation of Obstetric Practice in New York" by Grumbach and colleagues *(J Fam Pract 1997; 44:61-70)*, which concluded that no relationship existed between the level of increase in liability insurance premiums and the likelihood of discontinuing obstetrical practice.

First, the study is so old (1980-1989) that it is of little practical value to anyone. Second, I am sure a study conducted between 1990 and 1995 would reveal a significant reduction in the number of family physicians practicing obstetrics precisely because of liability malpractice premiums. My premiums alone would increase 300% if I chose to perform uncomplicated obstetrics.

J. Stephen Snoke, DO, MBA
Camp Hill, Pennsylvania

The preceding letter was referred to Dr Grumbach, who responds as follows:

In Reply:
I expect that Dr Snoke's letter captures the sentiments of many physicians aggrieved by the malpractice climate in the United States. Our study should in no way be interpreted as an endorsement of medical liability insurance as currently structured in this nation. Too many physicians are subject to frivolous lawsuits, too few patients who truly suffer from medical negligence receive compensation, and too much of the premium dollar is squandered on lawyers' fees.

That said, it is also true that no study has been able to objectively document Dr Snoke's assertion that liability insurance premium costs are a major factor in discouraging physicians from practicing obstetrics. We doubt that analyses of more recent data would show different results. For example, there has not been a major drop in the proportion of residency-trained family physicians performing obstetrics in the period mentioned by Dr Snoke. According to surveys conducted by the American Academy of Family Physicians, the proportion of family physicians practicing routine obstetrical care in the United States was 36.8% in 1990 and 35.2% in 1994.[1] As mentioned in our article, being singled out as the target of a malpractice claim does seem to exert a stronger influence on the decision to terminate obstetrical practice.[2]

Reducing premium costs for obstetrical liability insurance may have merit for other reasons, but it is unlikely to lead to substantial changes in the number of family physicians including obstetrical care in their practices. Perhaps the most compelling evidence on this score is the study by Nesbitt et al,[3] demonstrating that family physicians in California did not resume obstetrics even after liability premium costs fell by 25% in a single year—despite similar opinions among these physicians that malpractice costs were a decisive factor in their discontinuation of obstetrics. Policies to enhance family physician participation in obstetrical care will need to address the factors shown to be more important to this decision, such as lifestyle factors, lack of support from colleagues or systems of care, and competition from other obstetrical providers in urban areas.

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2. Rosenblatt RA, Weitkamp G, Lloyd M, et al. Why do physicians stop practicing obstetrics? The impact of malpractice claims. Obstet Gynecol 1990; 76:245-50.
3. Nesbitt TS, Arevalo JA, Tanji JL, et al. Will family physicians really return to obstetrics if malpractice insurance premiums decline? J Am Board Fam Pract 1992; 5:413-8.

CONSENT FORM

To the Editor:
As an assistant clinical professor in the faculty of family practice, I have continuous interaction with second-year residents in family practice. A concern that I have had all along is that patients may have the expectation that the attending physician is performing the procedure rather than the resident.

As a way of obtaining appropriate consent and to instill confidence in the patient that the procedure is being performed under supervision of their attending physician, I have developed a consent form (Figure). This is a standard form used in our clinics, our local hospital, and may be useful in other settings.

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FIGURE

LETTER OF CONSENT

Dear Patient:
We appreciate your participating in the continuous education of the residents of the Methodist Family and Community Medicine program. These residents are undertaking three years of specialty in family practice. They have had instruction, indications, contraindications, the procedure itself, and the ultimate management of their findings. This was all a part of their comprehensive program to become candidates for their certification in family practice. Procedures are performed under the direct supervision of the attending physician to ensure safety and competence.

Your participation is greatly appreciated. If you wish to make other arrangements, please let us know.