LETTERS TO THE EDITOR

THE BENEFITS OF GATEKEEPING

To the Editor:

Gatekeeping by primary care providers is often viewed with concern and even alarm.[1-4] Jerome Kassirer[1] opined in an editorial in *The New England Journal of Medicine* that "Market-driven health care creates conflicts that threaten our professionalism. . . . To keep expenses to a minimum, [doctors] must . . . use specialists sparingly."

What has been less discussed are the potential benefits of gatekeeping. If there is one overarching strength of the primary care provider it may be that of seeing the patient as a whole rather than as a sum of parts. Gatekeeping can have great value; value that should be available not only to the managed care patient, but to all patients. A patient drove this point home for me. A 37-year-old woman with multiple somatic complaints told of incidents of "passing out" over the past 24 years. The patient had made more than 200 emergency department visits to area hospitals in the last several years. She was seen by numerous emergency physicians, a neurologist, and a psychiatrist during that time. Her symptoms were diagnosed, in descending order of frequency, as gastroenteritis, dehydration, and suspected psychiatric disorder or functional disorder.

On presentation, the patient requested referrals to a neurologist and ear, nose, and throat specialist. She was concerned that her dizziness was due to an inner ear problem or some neurologic problem missed by the neurologist. I declined to make the referrals until I could review her chart and perform a complete history and physical examination.

The patient reported that her syncope was postural with an abrupt onset at the age of 13. A review of her records revealed that at age 25 she was treated for a "nervous breakdown" on a hospital psychiatric ward. At age 31 she underwent a total hysterectomy for endometriosis and reportedly "nearly died" during a stormy postoperative course.

The patient had a somewhat cachectic appearance. She demonstrated mild orthostatic changes in her heart rate but not her blood pressure. Laboratory results revealed: sodium 128 mmol/L; potassium 5.2 mmol/L. Because of the combination of a low serum sodium level without concomitant hypokalemia, adrenal disorder was suspected. Subsequent cortrosyn stimulation testing was flat: her serum cortisol at baseline was 7.1 µg/dL; 7.5 µg/dL at 30 minutes postinjection; and 7.0 at 60 minutes postinjection. Her ACTH level was markedly elevated at 1229 pg/ml. Computed tomography of the adrenal glands revealed bilateral atrophy.

After making a presumptive diagnosis of chronic Addison's disease due to an autoimmune adrenal disorder, I referred the patient to an endocrinologist for help with a treatment plan. The patient was treated with replacement steroids. She gained 29 pounds in 5 months and her orthostatic changes resolved.

Although it seems incredible that the patient could have escaped diagnosis for 24 years, a review of her chart showed that she had self-referred from emergency departments to specialists and back to emergency departments without a primary care provider as a gatekeeper.

Several possible errors resulted in delayed diagnosis in this patient. Perhaps the key clinical clue was her high potassium level in the face of significant hyponatremia. In addition, early orthostasis was either missed or felt to be of little diagnostic significance. Because the patient was generally seen only when she was acutely ill, clues to her underlying disease were missed. However, the patient's self-referral from various emergency departments to specialists in the absence of a gatekeeper presented a major barrier to making those observations and providing an accurate diagnosis. In addition, the inappropriate use of specialists resulted in false reassurances as well as misdiagnoses.

Although complex financial issues all bear on the use of specialists and special testing, gatekeeping can serve positive medical goals that should not be discarded in the discussion about managed care and cost-containment. Gatekeeping may be unfairly attacked as anathema to good care, especially when the issue is not really gatekeeping, but who carries out the gatekeeping and what incentives and disincentives are applied. As one author notes, "The gatekeeper phenomenon is automatic with well-trained primary care physicians."[5]

In fact, gatekeeping may not only assure proper diagnosis, but may protect patients from overtreatment, unnecessarily aggressive and invasive testing, and some of the devastating effects of iatrogenic morbidity and mortality.[6,7]

Although the patient described here may be relatively unusual, her case remains illustrative. A number of patients present on a regular basis to specialists and emergency departments with similarly missed, albeit

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more common, diagnoses because of limitations inherent in emergency or fragmented care. Occult alcoholism, abuse, and common medical problems with atypical presentations may remain undetected. While such patients may be a minority, they utilize medical services in great disproportion to their numbers.

In the case described above, the patient pursued an extraordinary amount of medical services. She visited local emergency rooms almost weekly for the past 24 years. The financial cost of such care can be calculated. The cost of a patient's life curtailed by a disease which kept her virtually confined to bed and sofa for 24 years is less readily imagined.

Jeanne M. Lenzer, RPA-C
Bassett Healthcare
Delhi, NY

REFERENCES

1. Kassirer JP. Managed care and the morality of the marketplace. N Engl J Med 1995; 333:50-2.
2. Emanuael EJ, Dubler NN. Preserving the physician-patient relationship in the era of managed care. JAMA 1995; 273:323-9.
3. Council of Ethical and Judicial Affairs, American Medical Association. Ethical issues in managed care. JAMA 1995; 273:330-5.
4. Clancy CM, Brody H. Managed care Jekyll or Hyde? JAMA 1995; 273:338-9.
5. Scherger JE. Does managed care contaminate practice? Fam Pract Management 1994; 94-100.
6. Franks P, Clancy CM, Nutting PA. Gatekeeping revisited — protecting patients from overtreatment. N Engl J Med 1992; 327:424-9.
7. Blumenthal D. Part 4: The origins of the quality-of-care debate. N Engl J Med 1996; 335:1146-9.

OFFICE BP MEASUREMENTS

To the Editor:

The *Journal* article by Pearce et al[1] brings to mind the time-honored question: Should blood pressures in clinical settings be taken with the patient seated or after resting supine for at least several minutes?

I was trained as a student, intern, and resident to take blood pressures from supine patients after they have had a short period of rest. The clinical dictum here was that this was standard and would be reproducible. It also seemed to eliminate the possibility of overtreating hypertension, either initially or in the course of therapy, with excessive dosages of drugs.

In my 20+ years of clinical practice, I have frequently seen patients overmedicated with hypertensive medications.

There is a common misconception that having the patient rest for several minutes in the supine position with the cuff in place is bothersome, unnecessary, and time-consuming. It has been my observation that it does not waste time; the patient simply rests while you are seeing another patient.

May I suggest that we reconsider the manner in which we take blood pressures, and return to using the supine position with the patient at rest?

Eugene Guazzo, MD
Maryland Infirmary
Chaptico

REFERENCE

1. Pearce KA, Evans GW, Summerson J, Rao JS. Comparisons of ambulatory blood pressure monitoring and repeated office measurements in primary care. J Fam Pract 1997; 45:426-433.

The preceding letter was referred to Dr Pearce, who responded as follows:

Dr Guazzo makes a very interesting point about the dilemma over which standards should be used for routine office blood pressure measurements. It seems that his experience matches mine in that resting supine blood pressure tends to be a bit lower than resting seated blood pressure in most ambulatory patients (though I cannot find any data to quantify our impressions). The crux of the issue, however, is the basis for the definition of hypertension and the recommendations for treatment that follow a diagnosis.

Estimates of cardiovascular risk associated with blood pressure levels, and the risk reductions associated with its treatment, come from large observational studies[1] and controlled clinical trials of antihypertensive treatment,[2,3] respectively. In almost all of these studies, blood pressure was measured in the resting, seated position. Therefore, the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure[4] and the American Heart Association[5] recommend that blood pressure be routinely measured after at least 5 minutes of rest with the patient seated, his back supported, and with his arm supported at the level of the heart during the readings. I agree with Dr Guazzo that the period of rest does not have to seriously interrupt office practice, provided that the physician and office staff plan for it as part of the routine.

Kevin A. Pearce, MD, MPH
Bowman Gray School of Medicine
Wake Forest University
Winston-Salem, North Carolina

REFERENCES

1. MacMahon S, Peto R, Cutler J, et al. Blood pressure, stroke and coronary heart disease, part 1: prolonged differences in blood pressure: prospective observational studies corrected for the regression dilution bias. Lancet 1990; 335:765-74.
2. Collins R, Peto R, MacMahon S, et al. Blood pressure, stroke and coronary heart disease, part 2: short-term reductions in blood pressure: overview of randomized drug trials in their epidemiological context. Lancet 1990; 335:827-38.
3. Pearce K, Furberg C, Rushing J. Does antihypertensive treatment of the elderly prevent cardiovascular events or prolong life? A meta-analysis of hypertension treatment trials. Arch Fam Med 1995; 4:943-50.
4. Joint National Committee. The sixth report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. Arch Intern Med 1997; 157:2413-46.
5. Perlof D, Grim C, Flack J, for the Writing Group. Human blood pressure determination by sphygmomanometry. Circulation 1993; 88:2460-67.

ALTERNATIVE PHARMACOTHERAPY

To the Editor:

In the December issue of the *Journal*, Dr Gillette[1] responded to an editorial about alternative medicine by criticizing the review paper published in *The British Medical Journal* regarding St John's wort. He writes, "Almost half of the 23 trials cited therein were of 4 weeks or shorter duration, and only one lasted as long as 12 weeks. This hardly represents solid evidence that such alternative pharmacotherapy has efficacy and safety comparable with the many antidepressant drugs now marketed..."

We should certainly hold any new treatment modality to the same standards as our currently accepted therapeutics. Just because a drug has passed FDA requirements to get to market does not mean, however, that it has been studied for long-term use. The recent debacle with diet drugs and our past experiences with anti-inflammatory drugs withdrawn from the market should remind physicians that the drugs we use everyday may not have been subjected to long-term studies. By reading the *Physicians' Desk Reference* entry for Prozac, for example, one finds that "The efficacy of Prozac was established in 5- and 6-week trials."[2]

I would also like to remind physicians that the manufacture of homeopathic remedies (not herbs such as St John's wort, but remedies prepared according to the homeopathic pharmacopoeia) is regulated by the FDA.

Lora M. Abell, MD
Unity Health Medical Group
St. Peters, Missouri

REFERENCES

1. Gillette RD. Alternative medicine [letter]. J Fam Pract 1997; 46:463.
2. Physicians' desk reference. Medical Economics, Montvale, NJ: 1998; 52:860.

LITTLE STUFF AS BIG STUFF

To the Editor:

Here are some thoughts I had after reading Howard Stein's editorial on the primary care science of the ordinary in the November issue of the *Journal*.

After Stein

Cruise walking through the tidy garden of a successful practice,
I come upon a messy opening.
A shallow, murky, muddy pond.
Disorganized water/land.

There, right in the middle, walking around barefoot
And filthy
Is a tall, thin man with beard.
(That's Stein, he don't look like no doctor.)

Now what's he doing to those gallant folks on shore?
Scooping up little clumps of mud
And whipping them right at 'em.
Big mud spots on white coats — he nailed some of them!
Tidiness dismayed.

Unsure of those thoughts.
Pokey things at my brain.
Bored with no answers.
Intrigued by the whole scene, baby!

Is he
Smiling or angry?
Teaching or demanding?
Wheat or chaff?
Science or chaos?
Yin and Yang.

Quick, turn away.
Turn the page.
Ahh, the relief of my peaceful garden.
Tending to my rare African orchids.
Familiarity breeds security.
Control the din, the ten thousand things.

Ron Hicks, MD
Venice, Florida

NOTES

1. Stein, HF. The primary care science of the ordinary: little stuff as big stuff [editorial]. J Fam Pract 1996; 45:394-6.
2. Tao Te Ching
3. ESP communication from Stein, November 25, 1997.