

# LETTERS TO THE EDITOR

## Second Order Versus Second Rate

### To the Editor:

In a recent article, O'Connor and colleagues<sup>1</sup> challenged all of us to be prepared to sacrifice for a second-order change in health care delivery. They conclude that this change must be driven by patient satisfaction—as related to “efficiency, continuity, patient-centeredness, comprehensiveness, and coordination.” There can be no doubt that primary care, and family medicine in particular, is the prototype of these physician-patient goals.

I am concerned that the article seems to stress the need for more ancillary services provided by nurses and so forth. The authors note that primary care is still structured around episodic care, “one visit at a time.” Dean Witter advertises that their success over the years has been “one investor at a time.” Can my money be more important than my health? When I go to see my physician, I want that person to listen and make decisions about my problems on the basis of current information, one visit at a time. The alternative could be that I am initially rolled into some algorithm and managed by someone less experienced and less knowledgeable than a physician. In today's world, when the current *Physician's Desk Reference* has more than 3000 pages and most comprehensive textbooks on primary care are going to 2 volumes, I want an experienced, extensively educated physician handling each visit.

But we all realize that keeping costs down is the main reason for the current emphasis on using primary care. I never understood this reasoning. Every time I communicate with the Health Care Financing Administration or an insurance company about reimbursement, I am reminded that physicians are paid for their services *irrespective of their specialty*. If this is the case,

then health care provided by subspecialists should not be more expensive than that provided by a primary care physician. Either this is not true, or subspecialists are providing different care than primary care physicians.

The other important issue that is seldom addressed is the declining social and professional status of primary care. Family practice became professionally respectable when the American Board of Family Practice was established to elevate board members to the status of specialist. The advent of health maintenance organizations, passively supported by the medical field, has degraded our specialty status to something we call a PCP—which sounds more like an environmental pollutant than a real doctor. Under any interpretation, it is something less than a specialist. This is not only false and misleading but also a true detriment to recruiting into family medicine.

Second-order change must be forthcoming, but not at the expense of quality. Primary care physicians must be reimbursed appropriately, just like other specialists. The social identity of primary care physicians must be re-established at the specialty level for the benefit of the profession and the satisfaction of the patient, who always wants to see a specialist.

We fly safely in commercial airplanes because the Federal Aviation Administration has relegated appropriate resources to training and to the technology to make it safe. And they do it one flight at a time. I don't want cheap help manning the radar scopes when I am 35,000 feet in the

air. I don't want the lowest paid provider available when I need a decision about my medication. Second-order, yes! Second-rate, no!

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Lynn Terry, RN

Medpath

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### REFERENCE

1. O'Connor PJ, Solberg LJ, Baird M. The future of primary care: the enhanced primary care model. *J Fam Pract* 1998; 47:62-7.

## Serum Chemistry Tests

### To the Editor:

In the August issue of the *Journal*, James Mold and coworkers<sup>1</sup> opposed serum chemistry panels in routine physical examination screening. I am behooved to write that this article was a poor exercise in utility, with respect to public health. I am a practicing physician with an MBA, who has routinely used large chemistry panels in pentennial examinations. I have had outstanding results in early diagnosis and prevention of disease. The benefits that this entails clearly outweigh any increased anxiety that patients may have experienced because of abnormal values. Furthermore, laboratory test values that the computer reads as abnormal are not necessarily abnormal values. They are just flagged to get the physician's attention. It is part of a physician's duty to order and interpret laboratory data. Mailing results to the patient directly is an inherently poor practice. Being a primary care physician and a businessman, I strongly oppose the findings in this article. I urge all practicing physicians to

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carefully weigh minor increased anxiety from false-positive laboratory values against the benefits of early diagnosis of diabetes, hepatitis, hypertension, thyroid abnormalities, and many more.

*Patrick R. Laraby, MD, MBA  
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#### REFERENCE

1. Mold JW, Aspy CB, Lawler FH. Outcomes of an insurance company-sponsored multichannel chemistry screening initiative. *J Fam Pract* 1998; 47:110-17.

#### **The preceding letter was referred to Dr Mold who responds as follows:**

Our study addressed only multichannel chemical screening conducted by a nonclinical entity (ie, an insurance company). Dr Laraby is apparently concerned about the screening that he does in his practice. His concern has, however, been addressed previously by others.\* Based on this literature, Medicare will no longer pay for serum chemistry tests ordered by physicians that have no specific indication.

It is difficult to quantify the benefits of discovering abnormalities that lead to new diagnoses or treatments, since patients often don't follow advice and the risk:benefit ratios for many conditions are unknown. It is equally hard to measure the adverse effects. It was for this reason that we chose to look at health-related quality of life as an outcome measure that might give an overall picture of both positive and negative outcomes. That the health-related quality of life was unchanged to somewhat worse at 6 to 9 months does not, however, rule out a longer-term net benefit from screening. There is really no way to know whether the anxiety that sometimes results from screening is minor. Others have reported increased absenteeism from work, lower subsequent salaries, reduced

self-image, and depressive symptoms in adults after they were told that they had hypertension.

We wholeheartedly concur that physicians should look at the individual laboratory test values and make a clinical judgment regarding their importance. Unfortunately, in the setting that we studied, nearly 50% of patients received their test results and never consulted a physician. In a previous paper, we also pointed out that, because of the way that reference ranges are commonly set, results falling outside of the suggested reference limits are generally even more "abnormal" (perhaps we should say "unusual").

*James W. Mold, MD  
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#### **Walking in Labor**

##### **To the Editor:**

The October 1998 issue of the *Journal* contains a review by VandeKieft<sup>1</sup> of the recent article in the *New England Journal of Medicine* by Bloom and colleagues.<sup>2</sup> This well-publicized study concluded that walking in labor did not provide any particular benefits. On the other hand, there were no negative consequences.

In evaluating evidence-based medicine to determine if the results apply to one's own particular practice, the most critical issue is the setting where the study took place. The most striking feature of the Bloom study was that at the point of randomization the cervical dilatation was 4 cm for both the experimental and the control arms. This means the women were well advanced in the active phase of labor. Many of them may have done a substantial amount of walking before they arrived at the hospital, but their labor in the hospital may have been too intense to walk. In fact, 22% of those allocated to walking did not walk. This is not a problem, it is sim-

ply a description of what occurs for many women in the very active part of the active phase of labor. Additionally, it should be noted that the epidural rate for the 2 arms of the study was between 5% and 6%. The cesarean section rate was 4% to 6%, and the forceps rate was 3% to 4%. This tells us that this study took place in a setting with very low intervention rates, particularly pertaining to cesarean section. The rates in this Texas setting are enviable indeed.

Rather than suggesting that walking in labor does not help, this study shows that if you look after women well and admit them to the hospital in an advanced stage of cervical dilatation, you will get good outcomes. If your institution has a cesarean section rate of 4% to 6%, the most appropriate thing to do is more of whatever it is that you are doing.

Rather than suggesting that walking is not useful, the most appropriate response would be to celebrate your success in managing labor well while recognizing that with a cesarean section rate between 4% and 6% you are not likely going to be able to improve on that by walking, talking, partying, jumping up and down, or whatever. There is almost no room to demonstrate the study effect.

If your institution has a cesarean section rate in the range of 25%, however, walking may very well be helpful, but probably the most important thing that you can do is address your management of women in the latent phase of labor and in early labor and whether in either of these situations they belong in the hospital at all.

*Michael C. Klein, MD, CCFP  
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#### REFERENCE

1. VandeKieft GK. Lack of effect of walking on labor and delivery. *J Fam Pract* 1998; 47:254.
2. Bloom SI, McIntire DD, Kelly MA, et al. Lack of effect of walking on labor and delivery. *N Engl J Med* 1998; 339:76-9.

\*The references for this letter are available on the *Journal's* Web site at [www.jfp.denver.co.us](http://www.jfp.denver.co.us).

## Ugly Stepchildren?

### To the Editor:

I recently received a rejection letter in response to my application for an American Academy of Family Physicians (AAFP) advanced research training grant. Some of my previous work has been turned down by the finest medical journals, so I'm used to rejection. But this particular letter did make me stop and think.

This letter mentioned the depth and quality of the 102 submissions and then announced that only 9 individuals were invited to submit full proposals. It went on to say, "The Task Force does wish to point out, however, that these grants are for research *training*. Many applicants did not include sufficient information on a training component with specific education goals and only asked for protected time."

It seems to me that one of the great barriers to family practice research has always been that the institutions that contain the infrastructure and culture that supports research—the tertiary care center-affiliated medical schools—are far removed from the places where family practice reaches its fullest potential: community-based residencies and practices. Family practice residents in tertiary care centers are universally treated like ugly stepchildren, and the faculty don't seem to fare much better. I cannot quote any studies to support this opinion, but I'm sure every family physician knows what I'm talking about.

I recently completed a course of study with the National Institute for Program Director Development, that (if nothing else) was a great forum to learn that my own barriers to research funds were shared by pro-

grams across the country. Every program represented seemed to have problems grounded in this reality: So much of the funding for family practice training goes directly to the sponsoring hospitals (indirect medical education, direct medical education, dedicated state funds, and so forth). After this funding winds its way through the Byzantine hospital accounting system, the family practice faculty is left with an amount that allows for little more than direct patient care or supervising residents providing patient care. Protected time for research isn't even on the radar screen.

Even the AAFP Foundation's Joint Grant Awards Program states, "If salaries are included for investigators who are also full-time faculty members, justification must be provided as to the need for funds to cover this compensation."

Practice-based networks provide a bridge between the strengths of the medical school family practice department and community experiences, but they have their own unique limitations.

The AAFP has announced its commitment to expanding the research capacity of the specialty. The task force has allowed 9 individuals to go forward with their proposals, and I'm sure good information will come from their work. The reality is that physicians are available to expand the research capacity of the specialty. Ninety-three family physicians have provided feedback that further education isn't the main barrier, protected time is. I hope the AAFP and other institutions interested in expanding primary care research are listening.

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## Not an Ideal Study

### To the Editor:

I read with interest the elegant review by Smucny and colleagues<sup>1</sup> in the December issue of the *Journal*. I use the adjective "elegant" to denote the distillation of the maximum amount of useful information from the minimal amount of available data. As noted by the authors, the number of patients in the meta-analysis (779) is insufficient for subgroup analyses, and the largest trial (212) is also the oldest (performed in 1976).

I offer my concept of some necessary characteristics of the ideal (descriptive or interventional) study of acute bronchitis: a large number of patients (probably numbering in the thousands) enrolled from geographically dispersed primary care settings over at least 5 years (to account for microbiologic periodicity). In addition to relevant clinical variables, I believe that meaningful studies of acute bronchitis must include objective measures of pulmonary function (including reversibility) and comprehensive evaluation of microbiologic causes for bronchitis; without subgroup analyses based on these variables, I doubt that clinicians will ever have access to the information they need to provide rational antibiotic prescribing for acute bronchitis in otherwise healthy patients.

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### REFERENCE

1. Smucny JJ, Becker LA, Glazier RH, McIssac W. Are antibiotics effective treatment for acute bronchitis? A meta-analysis. *J Fam Pract* 1998; 47:453-60.