LETTERS TO THE EDITOR

Does Gender Play a Role in Exemplariness?

To the Editor:

The study by Marvel and colleagues[1] of interviewing by exemplary family physicians, although interpreted in the accompanying editorial[2] as finding that exemplary family physicians were more psychosocially involved with their patients, suffers from a confounding of exemplariness and physician and patient gender. Proportionally, more than 2 times as many of the exemplary physicians were women (33% vs 15%), and their patients were also more likely to be women (67% vs 52%). A further confounding effect is that community physicians were randomly selected from northern Colorado, while exemplary physicians were identified and drawn from throughout the United States and Canada.

In addition, the notion that exemplariness can be equated with having further training in family therapy is a debatable one. If specialized training is the hallmark of exemplary care, family physicians as a whole might stand accused of failing to provide exemplary care by virtue of their lack of specialist training.

A more sanguine summary of the study's findings would be this: Psychosocial involvement is higher among a selected group of American and Canadian physicians who have training in family therapy, who are more likely to be women, and who are more likely to have female patients, when compared with a random group of northern Colorado physicians. Only an analysis by physician and patient gender, with independent criteria for exemplariness, could justify the interpretation made in the accompanying editorial.

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REFERENCES

1. Marvel MK, Doherty WJ, Weiner E. Medical interviewing by exemplary family physicians. J Fam Pract 1998; 47:343-8.
2. Campbell TL. Medical interviewing and the biopsychosocial model. J Fam Pract 1998; 47:339-40.

The preceding letter was referred to Drs Marvel, Doherty, and Weiner, who respond as follows:

We appreciate the opportunity to respond to Dr Glaser's comments about our article on exemplary family physicians. Dr Glaser points out potential confounding variables that, if not addressed, would warrant a more limited and refined interpretation of the results. We would like to present additional data to address some of these concerns about confounding effects, and to again acknowledge the limitations that were stated in the original article.

Because of space limitations, our analysis of the relationship between exemplary status and gender received only the statement: "A comparison of physician and patient gender showed no significant differences." We, too, were interested in a possible relationship between exemplary status and the gender of physician and patient, especially given the overrepresentation of women in the exemplary group. We calculated the average level of involvement in the set of interviews conducted by each physician. An average of 1.5, for example, would indicate that the physician's level of involvement, on average, fell midway between level 1 and level 2. Higher levels correspond to more psychosocial involvement with the patient.

Our analyses yielded the following results, none of which were statistically significant. The associations of physician gender with the highest mean level of physician involvement were as follows: female physicians, 2.0; male physicians, 1.8; female exemplary physicians, 2.0; and male exemplary physicians, 2.6. An analysis of patient gender and the mean level of physician involvement yielded the following results: female patients, 1.9, and male patients, 1.8. Finally, an analysis of possible interaction between patient and physician genders showed the following results: female physicians with male patients, 2.1; female physicians with female patients, 2.0; male physicians with female patients, 1.9; and male physicians with male patients, 1.7. On the basis of these statistically nonsignificant findings, we could not conclude that the gender of the physician or the patient was a variable for explaining the higher levels of involvement shown by the exemplary group.

Dr Glaser also calls into question equating exemplariness with having fellowship training in family therapy. Our research design required a group of physicians with a high level of psychosocial skills. To identify such a group, we relied on objective training credentials. In selecting this criterion, we assumed physicians who sought and received specialized training in family therapy and communication skills would integrate psychosocial issues into their medical interviews. Our intention in using this

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criterion was to create a valid study design, not to suggest that all family physicians learn family therapy. We do not conclude, nor do we state in our article, that family physicians must undergo specialized training to provide exemplary care.

Finally, physician practice location was identified by Dr Glaser as an additional confounding variable. We agree that selecting community physicians from one location (northern Colorado) to compare with fellowship-trained physicians drawn from throughout the United States and Canada could have affected the results, although we have no specific reason to believe this variable would affect the level of physician involvement. This limitation is acknowledged in the article.

We thank Dr Glaser for his interest in the study and for reminding us of the caution necessary when conducting applied research.

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Regular Providers for Diabetes Care

To the Editor:

The study by O'Connor and colleagues[1] argues that having a regular provider of care is associated with better diabetes care and glycemic control. Although the findings are certainly plausible, we are concerned that the primary variable, having a regular care provider, was ascertained solely by asking patients if they had one provider in particular who cared for their diabetes. Using this approach, 90% of all patients were classified as having a regular care provider—a distribution so skewed that virtually all patients with diabetes were included.

It would have been more accurate to determine whether a patient has a regular provider (and the identity of that provider) on the basis of the actual visits the patient made for the care of his or her diabetes. It would also be interesting to know whether outcomes are related to the discipline of the regular provider, and the extent to which that provider treated problems unrelated to diabetes.

Case-mix adjustment is a critical factor in the analysis of quality of care and outcomes. Disease severity in the 2 groups was assessed only by patients' self-reported knowledge of comorbid conditions. Given the rich database from which the authors can draw, we would suggest using one of the more standard approaches to case-mix adjustment.[2]

The authors conclude that there is a relationship between having a regular primary health care provider and the quality of diabetes care. As much as we would like to believe that conclusion, the evidence presented in this paper seems to be based on a rather insecure methodological foundation. As primary care physicians with an inherent conflict of interest, we have an extra responsibility to subject our conclusions to the same skepticism to which they will be subjected by others. Given the sources available to these authors, it would be worthwhile to reanalyze the results using the full potential of the data set.

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Roger Rosenblatt, MD, MPH
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1. O'Connor PJ, Desai J, Rush WA, et al. Is having a regular provider of diabetes care related to intensity of care and glycemic control? J Fam Pract 1998; 47:290-7.
2. Starfield B, Weiner J, Mumford L, et al. Ambulatory care groups: a categorization of diagnoses for research and management. Health Serv Res 1991; 26:53-74.

The preceding letter was referred to Dr O'Connor, who responds as follows:

I appreciate the chance to respond to the concerns of Drs Chen and Rosenblatt. I am happy to report that the additional analysis of claims data to ascertain the impact of formal measures of continuity of care is currently under way. However, my colleagues and I felt it was important to report on the relationship of patient perception of having a regular provider of diabetes care for 2 reasons. First, patient perceptions are legitimate data and may have a strong impact on health-related modifiable risks. Second, in an era when chronic disease carve-out models are being widely implemented in advance of data to support their effectiveness, we felt it was important to document the observed positive relationship of having a regular provider of care to more intensive diabetes care and better glycemic control.

Although it is true that only 10% of the study subjects had no regular provider of care, this proportion is nontrivial from the population point of view. On a national basis, 10% of those patients with diagnosed diabetes calculates to more than 1 million people. Factors that may lead to improvement strategies for such a large group of people are well worth exploring.

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Kudos for Supplement on Diabetes Care

To the Editor:

Kudos to Drs Kevin Peterson, Patrick O'Connor, Stephen Spann, and their colleagues for providing an excellent up-to-date and balanced review of diabetes care in the November supplement[1] to the *Journal*. I read the issue from cover to cover and will use it as a key resource for practice and teaching. The authors' practical recommendations and clear understanding of the real-world practice environment were refreshing.

Thank you for a great service to our specialty.

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1. Peterson KA, ed. Type 2 diabetes mellitus: the evidence for current therapy. J Fam Pract 1998; 47:S1-64.

Playing Clinical Jazz

To the Editor:

I am most appreciative of the article by Shaughnessy and colleagues[1] and their metaphor of good clinical care as harmonic jazz: a synthesis of structured evidence-based scientific recommendations and the creative energies subsumed under the rubric of clinical experience. I agree completely with the need for this synthesis.

Yet, I am struck by the apparent breakdown in the metaphor as I struggle to place the patient within this harmonic menagerie. Certainly the patient may represent an instrument for our knowledge and skills — and this may, at first glance, seem appropriate. However, it denies the important role that patients play in our decisions and our process of care. It also elevates physician authority to a level much higher than is comfortable for many family physicians. I would suggest that the patient's preferences and insights, when coupled with the evidence-based knowledge and our clinical experience, are what allows the opportunity to create great clinical jazz. But we also run the risk of discord when patient preferences counter our best intentions. Here, also, we must attempt to find harmony.

Knowledge is useful when it helps us make decisions in the face of uncertainty. How and when we apply evidence-based medicine and clinical experience in the presence of verifiable uncertainty is the challenge for research in primary care. Patients are crucial participants in our quest to make collaborative decisions based not only on our knowledge, but also on understanding our patients and their life goals.

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1. Shaughnessy AF, Slawson DC, Becker L. Clinical jazz: harmonizing clinical experience and evidence-based medicine. J Fam Pract 1998; 47:425-8.

To the Editor:

The article on clinical jazz by Shaughnessy, Slawson, and Becker in the December 1998 issue of the *Journal* struck a note that resonated with some of my thoughts about the role of evidence-based medicine in the actual practice of family medicine. Clearly we need to think about the ways we know what we do, even though not all of those ways are easily subjected to the methods of evidence-based medicine.

I think there are 3 primary ways of knowing the therapeutic things we do. (I think the same ways probably apply to information gathering and diagnostic tasks.) There are certainly some evidence-based things I do. These have some degree of scientific certainty. The process of research increases my confidence in my effectiveness in these therapeutic (and diagnostic) maneuvers. There are also a number of things I have learned that I consider the craftsmanship of medicine. Some of these are things that might eventually be examined by the scientific process, but most are just handed down as conventional wisdom or clinical pearls during the training process.

Then there are other things I do that relate more to the meaning of disease or illness, and are approached by the spiritual aspects of the physician-patient relationship. It is tempting to not include these aspects in our scientific evaluation of what family docs do, but they are among the most rewarding parts of information gathering and therapy. In training, these are taught through Balint groups and through direct attention to the spiritual side of the ongoing relationship between doctor and patient.

Many years ago the only component of these ways of knowing that was a part of the physician's armamentarium was the spiritual or priestly or shaman role. Then, perhaps during the 18th and 19th centuries, the craft of medicine became more prominent. The mentor-pupil relationship was primary in medical education, and the physician-patient relationship emphasized an authoritarian expertise. In the 20th century, scientific examination added an open evaluation of treatments and procedures that have demonstrated effectiveness. Scientific examination has also had the effect of opening our relationship with patients to include a mutual review of the data and shared decision making.

I believe that physicians are most effective in relating with patients when we can incorporate all of these aspects of what we know, and when we can play the various roles implied by these different ways of knowing. We then can blend them into a unique approach that grows out of the unique needs of each individual encounter (and the ongoing relationship that ensues).

It seems clear that one cannot practice medicine without incorporating at many levels all of what goes into the improvisation that is the care of the patient.

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Correction

In a POEM published in the February issue (Epling J, Taylor H. Low-dose omeprazole for erosive esophagitis. J Fam Pract 1999; 48:93-94), the correct dosages of omeprazole used in the study were 20 mg and 40 mg per day. The recommendations for clinical practice are correct as printed.