

TO THE EDITOR:

It can be frustrating to treat patients who are high users of health care but whose clinical presentation allows us no clear focus for intervention and remediation. Dr. Smith and colleagues¹ clarify that, contrary to popular thinking, the majority of patients who are high users of medical care are not necessarily somatizing, and that most of those patients have minor acute medical illnesses. However, we also should acknowledge that the costs of caring for somatizing patients are disproportionately high.² Special effort is required to intervene if changes in clinical course and utilization are to occur.

Also, it is quite possible that the minor acute medical illness group contains a significant number of patients with psychiatric disorders other than those frequently seen in primary care, such as depression, substance abuse, or anxiety disorders, since as many as 50% or more of patients who present with comorbid psychiatric conditions have physical symptoms rather than psychological symptoms.³ The use of standardized psychiatric measures oriented to primary care populations will better delineate this clinical population and help us respond to their complicated treatment needs.

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DR SMITH RESPONDS:

We were surprised to find so many patients who did not fit the criteria for somatization. We had not considered that, among high users of care, we would find anything other than organic disease and somatization along with some patients with predominantly psychiatric illness, such as depression. While much work remains, there appears to be a rather large group of previously unstudied patients with what we have descriptively called minor acute illness (MAI). We are presently studying whether the costs for MAI are similar to those for somatization, and we are studying the psychological and psychiatric profiles of both somatizing patients and patients with MAI. Because we rated only a patient's primary diagnosis during the year, we agree it is likely that we will find considerable comorbid psy-

chiatric illness in patients with MAI, as well as in somatizing patients. We are conducting a randomized controlled trial to determine if a 12-month intervention by primary care personnel is effective. It uses cognitive-behavioral principles and, for the first time, a strong systematic emphasis on the provider-patient relationship. We also have identified a simple screening test using an administrative database that, with further study, may be useful in identifying somatizing patients for treatment.¹

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TO THE EDITOR:

I read with great interest the article by Miller and colleagues¹ on understanding variation in practice. I agree completely with their thesis that improving the quality of care for our patients will not, and cannot, come simply by standardizing how that care is provided. One key point to address is the difference between variation in the structure and process of patient care as opposed to variation in the content of care.

It is certainly clear that practices vary in how they are structured and how they take care of people. The differences between small 1 or 2 physician practices and large groups (to simplify the issue) offer patients options with regard to the type of environment in which they receive health care. Some physicians are very efficient and are always on time, while others may run late but always give patients the time they need. Eliminating this type of variation would be difficult if not impossible to accomplish, and would likely add little to the quality of care.

Variation in content of care is probably more important in addressing quality concerns. One model divides what we do into 3 categories.² One category includes those tests and treatments for which scientific evidence suggests a clear benefit (eg, beta blockers after myocardial infarction, some immunizations, simple counseling regarding tobacco cessation). In these cases, the intervention should be offered to all appropriate patients, and any variation from this approach would likely decrease quality. The second group is made up of those medical interventions for which evidence is not clear (eg, treatment of benign prostatic hypertrophy or the best approach to colon cancer screening). In

these cases, a shared decision-making approach, presenting patients with information about the alternatives, and having patients actively involved in the treatment, is probably the way to improve quality. This approach may lead to variation if there are regional differences in patient values and preferences. The final group includes medical interventions for which there is good evidence that more is not better (intensive end-of-life care, antibiotics for most respiratory infections). In these cases, variation in the direction of doing more should be minimized to improve overall quality.

To the extent that we see our role as providing the best information we have to our patients and then working with them to make decisions about care that are consistent both with our scientific knowledge and with their values and beliefs, the rich variations that Miller and colleagues point to will not be lost in a standardized medical world. Our patients, our staff, and our own individuality will continue to contribute to creative variations in how we do what we do.

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DRS MILLER, CRABTREE,
AND STANGE RESPOND:

Thank you, Dr. Korsen; we agree! The distinction between the structure and process of care and the content of care may have different implications for understanding variations in care. If only it were so simple. Variation is good, but....

Variation in structure and process is essential if family practices are to remain responsive and adaptive to local assets, needs, and values. We suggest that trying to eliminate this type of variation would not only add little to improving quality, but could worsen it. On the other hand, unfortunately, there are too many family practices with structures and processes that are not responsive to their communities. Process errors, inadequate accessibility, and poor documentation are just some examples of this troublesome variation.

The 3-category classification of content-of-care quality concerns is a helpful one. We agree that greater variation in those areas where there is no scientific evidence of clear benefit is useful guidance and an excellent starting point. The suggestion that

variation is more problematic when there is scientific evidence of clear benefit or good evidence that "more is not better" is less certain. Some variation in these areas may also be good. The commonly accepted standard for "scientific evidence" is the randomized controlled trial (RCT), which is a practical but flawed standard. Most RCTs use disease-based outcomes as their criteria of benefit. Application of RCT results to populations in their ecological context assumes that maximizing control of each individual disease will result in better overall health. There is no evidence to support this assumption, and some evidence to challenge it.

Countries with greater proportions of primary care (and all the content of care variability we know goes with that) have better overall health status, even after controlling for demographics and socioeconomic factors.¹ This is true even though there is good evidence that specialists generate better disease-specific process of care measures than generalists.² This apparent anomaly is not a surprise from a complexity science point of view. The health of a complex adaptive system, such as a human organism, a community, a practice, or an ecological system is always much, much more than the sum of its parts. There are so many interconnections, delayed feedback loops, altered communications, and chance occurrences, and each part of any system has its own peculiar outcomes. This is why standardization, from an evolutionary point of view, always leads to extinction as environmental niches open and close. There is more to health than the control of disease.

We continue to assert that variation in all things is good but that some variations are better than others and some are harmful. Thus, the real challenge for family practice is to establish better systems of ongoing scrutiny of care as it relates to patients, communities, and practices. More than ever, there is a need for all practices to become part of some participatory practice-based research network. This research will need to include measures of system outcomes. Family physicians have always known that there is more than one appropriate way to care for each patient. Our study supports this intuition. Now, it is our responsibility to be sure that the many ways are all good.

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Benjamin F. Crabtree, PhD
Kurt C. Stange, MD, PhD*

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