ERRATUM

In "Which smoking cessation interventions work best?" (Clinical Inquiries, July 2011, page 430), one of the authors was misidentified. The correct list of authors is: Tracy Mahvan, PharmD; Rocsanna Namdar, PharmD; Kenton Voorhees, MD; Peter C. Smith, MD; and Wendi Ackerman, MLS, AHIP. Ms. Ackerman is affiliated with the Health Sciences Library, Upstate Medical University, Syracuse, NY.

Does the D-dimer get too much or too little weight?

"Looking Beyond the D-dimer" (*J Fam Pract.* 2011;60:400-403) left me quite confused. The authors described a patient for whom the Wells criteria and a D-dimer were negative for pulmonary embolism (PE) initially but who did, in fact, have a PE. They point out "a key problem with the Wells criteria" and show that the D-dimer was inaccurate, at least relatively early on. Yet they conclude that physicians should use the Wells criteria to evaluate patients and should not work up a patient with a negative D-dimer—which was less than reliable in the case they described.

If, after all of our training and experience as physicians, we are being taught to rely on algorithms and moderately and/or inconsistently reliable tests, we can all retire and let our computers do our jobs. Although I am concerned that much of modern medicine is dictated by health insurers or driven by fear of malpractice claims, we should not exclude clinical judgment and professional acumen. Nor should we read and live by articles that offer contradictory advice.

Doctors, you can't have it both ways.

Barry Marged, DO, MA
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The authors respond

My colleague and I read your comments with interest. We believe that our case study provides an important message: Utilize evidence-based algorithms that exist in the literature to the best of your ability, but never lose sight of your clinical instincts. These "resources" are complementary, not mutually exclusive.

Good communication with patients affords us the opportunity to stay involved with the evolution of their clinical status and always be ready to reassess. In our case presentation, the Wells criteria allowed us to incorporate the algorithmic thinking into our clinical judgment, but not to replace it. The patient's ongoing symptoms required a reevaluation, and the Wells criteria proved their worth the second time around. No harm was done to the patient as the PE turned out to be distal and small.

In the end, no clinical algorithm can deliver a guaranteed outcome. In this era of rigorous scrutiny, evidence-based medicine, and cost-effective care, criteria such as the Wells are particularly important. Avoiding unnecessary CT angiography while maintaining close contact with a patient, or assuring immediate follow-up (in the case of an emergency department evaluation) saves valuable resources that can then be deployed elsewhere. Thoughtful rigor, combined with open-mindedness and trust in our clinical instincts, is the way to deliver value-driven, high-quality care.

H. Andrew Selinger, MD
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There's more to a visit than refilling meds

Dr. Susman's editorial, "Rethinking our approach to refills" (*J Fam Pract.* 2011;60:385), seems to imply that many patients are given appointments simply to have their medications refilled. While I do see the occasional patient for a med list review, this is rare in my busy practice. Indeed, if the only service I provided was a prescription, my job could be done by a robot.

I strongly disagree with the contention

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that yearly visits are enough to provide quality care to patients with chronic conditions. Treating long-term disease involves more than simply taking a medication.

I was taught, and still believe, that there is no substitute for "laying eyeballs" on a patient. A wealth of useful information can be gleaned from walking into a room and simply looking at a patient for 10 seconds. Does she look healthy, or appear anxious or depressed? Is she breathing easy or rapidly? Even the way a patient sits in the chair provides invaluable data points.

Seeing patients more frequently also provides more opportunity to discuss health maintenance and practice preventive medicine. Many chronic conditions can progress slowly and subtly, and cause deterioration over time. By seeing patients 2 or 3 times a year, we are more likely to detect problems earlier and deal with them in a more timely (and thus more cost-effective) manner.

I have no problem writing prescriptions good for a year, as Dr. Susman suggests. And I agree that patient compliance with medications is a problem, but I do not agree that simply refilling prescriptions without the opportunity to explain, educate, and evaluate issues such as side effects and cost will increase compliance. Better to sit down and discuss such issues with the patient.

I suspect my staff and patients appreciate this approach. When I'm the patient, I know I do.

Robert J. Pizziketti, MD
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I very much appreciated Dr. Susman's editorial, "Rethinking our approach to refills."

I've been saying the same thing for years, largely in vain, and the editorial triggered a lively and very productive discussion in our residency program's journal club.

We concluded that prescribing a month's worth of medicine with no or few refills for well-controlled chronic conditions like diabetes, hypertension, or arthritis with the intention of requiring that the patient return for an office visit in 1 to 3 months has various outcomes:

- Some patients may come in sooner; many others will run out of medication and have a recurrence, and worsening, of their condition.
- Calls for refills will clog the office phone lines.
- Some patients will be resentful, feeling that their prescription refills are being held hostage by their physician.
- The additional visits (and co-pays) will be inconvenient for many patients and a financial burden for some.

Alternative means of encouraging office visits, such as e-mail, telephone, and regular mail reminders, may be more appropriate and effective for getting patients to return at rational intervals for follow-up.

The take-home lesson: Write a year's worth of refills. Doing so lets patients know that your primary focus is their health and well-being.

Michael Crouch, MD, MSPH
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Dr. Susman's question—"So why not make it easier on patients and write a year's prescription for most routine medications?"—may have been rhetorical, but the answer is "financial incentive" more commonly than most of us would like to admit. Our current system rewards churning, the habit of seeing a high volume of low-acuity patients. The ratcheting down of primary care reimbursement has made this habit one of necessity and survival for many physicians.

A much more efficient, cost-effective, higher quality, and patient-friendly approach is just the opposite: seeing patients less frequently, but for longer visits, with more time spent on patient education. This more thoughtful, careful approach decreases the tendency to be a "triage" doctor and to overorder labs and imaging. Payment reform will probably be slow and haltingly implemented, but it is coming.

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