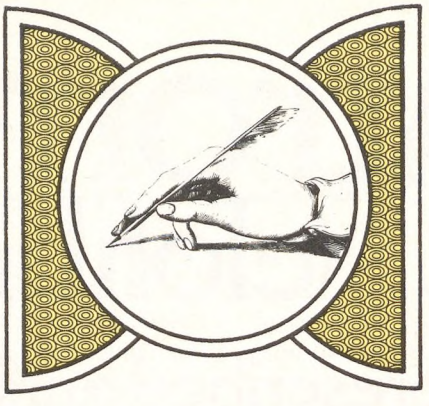
Letters to the Editor



The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Outcomes of Acute Care

To the Editor:

Any attempt to measure quality of care is to be applauded, but a recent paper by Kane RL et al (*Differences in the outcomes of acute episodes of care provided by various types of family practitioners. J Fam Pract 6:133, 1978*) cannot be allowed to pass without comment. The results of their study imply differences between providers in terms of outcome and patient satisfaction. We have a number of misgivings about the validity of these results, and these doubts are particularly related to the lack of evidence of standardization in the methods described.

We would like to pose the following questions.

1. The paper refers to a prior publication (*Kane RL et al: A method for assessing the outcome of acute primary care. J Fam Pract 4:1119, 1977*), which indicated that age and sex had no effect on measurements of outcome in acute care. Are we to assume that this was also true for the symptoms and diagnoses in the latest study? Did providers see patients from similar age groups, and with similar sex distribution?

2. The methods described made no reference to socioeconomic status of patients. Do the authors consider that this factor has no effect on outcome and patient satisfaction? Was the range of patients from varying socioeconomic groups similar for different providers of care?

3. Is the inclusion of only two physician's assistants acceptable when comparing the activities of a range of primary care providers? We believe that this very small sample of physician's assistants invalidates a number of the conclusions rendered.

4. Was any staging process used in identifying patients with similar problems? For example, it may be reasonable to suggest that the outcome would be different in a patient who presents with a headache of 24 hours duration, as opposed to a headache of one week's duration.

5. The authors indicate that patients with chronic problems were excluded from the study. Nevertheless, many patients with acute symptoms and illnesses will have associated problems of physi-

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cal, psychological, and social origin. How many patients in the study had associated problems and, if these factors were included, what effect did they have on outcome?

We do not wish to appear carping in our criticism, but we firmly believe that rigorous attention to detail is necessary when attempting to measure quality of care.

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The preceding letter was referred to Dr. Kane who responds as follows:

Drs. Bain and Coggins raise a number of very pertinent questions about any study which would purport to measure the quality of care. There is growing recognition that this type of activity is particularly difficult in the primary care arena where the spectrum of services is wide. I would like to take this opportunity to respond to some of their questions in the order that they raised them.

1. The earlier paper emanating from the same study that prompted their letter was intended to provide some background data about the methods used in the outcome assessment technique. The data reported there on the lack of any effect of age and sex on measures of outcome would therefore apply directly to this study since it is the same data. It should be underlined that the population covered by the particular family practice clinics in which this study was based had a relatively narrow age range: only six percent of the patients were over the age of 50; 60 percent were female. There were no significant differences in the age or sex distributions of the patients seen by various provider types.

2. The omission of socioeconomic status from our description of the patients was not based on a lack of concern about its potential effects on either outcome or satisfaction. Unfortunately, no measures of this variable were included in the study instrument and there was no way of identifying socioeconomic status from the clinic charts. The general perception of the providers of care suggested that there was no discrimination among the various providers along the dimensions of socioeconomics, status, age, or sex.

3. It would have been highly desirable to involve more than two physician's assistants in the study. Unfortunately, this represented the universe of those available. Several well-done studies have shown very similar results with equally small sample sizes. Taken as a total group, the growing body of literature on the performance of physician's assistants and nurse practitioners would suggest that the quality of care provided is equivalent to that of physicians, at least for those problems with which the PA and NP deal.

4. No specific staging process was used to reclassify diagnostic groups to more specific clusters. One of the major problems was the lack of adequate sample size. Given the heterogeneity of problems presenting at the clinics, we had difficulty in defining suffi-

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ciently large groups of patients with the same diagnosis to compare outcomes. We did, however, try to control for potential variables in our analysis. For example, Table 1 in the paper, although badly mislabeled typographically, controlled for the presenting functional status. We have in other analyses not presented in this paper looked at the accuracy of physician predictions about the outcomes of their patients. This, in essence, represents a staging of each case by the physician. When we did this, we noted that physicians could correctly predict the cases with good outcomes at better than 95 percent; however, the predictions of the cases of the poor outcomes were in the range of less than 15 percent. The PA accuracy of prediction fell between those of the various providers.

5. Many of the same points can be raised in terms of the questions about the presence of chronic illness. Chronically ill patients represented only a small minority of the overall patients seen. If one looks at the larger question of how many patients had associated problems, then the potential number of patients included becomes much larger. The clinic utilized the problem-oriented record system which encouraged the providers to note as complete a set of problems as possible. We did not utilize this data in our analysis, however. To the extent that the providers felt that these factors were important in terms of their effect on outcome, they would have been included in the provider's prognosis. As we have already noted, that prognosis tended to underestimate the individuals with bad outcomes.

The comments of Drs. Bain and Coggins are important in underlining the need for careful replication of studies like this one. This effort represents our second such study, with some minor modifications, particularly in regard to the follow-up technique used. The results were generally consistent between the two studies. The results were also consistent with basically similar approaches used in a study of private practice (JAMA 236: 2509, 1976). We would hope that others in family practice might be stimulated to undertake similar studies of the outcomes of primary care. We are especially anxious that someone identify a feasible means of tracking the outcomes of that large body of primary care activity which generally falls under the rubric of health maintenance.

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Cognitive Skills and Clinical Performance

To the Editor:

I am deeply troubled by one hypothesis and one result stated in Dr. Parkerson's paper, Labstand: A Computerized System for Reporting Clinical Laboratory Data in Standard Units, in your March issue (*J Fam Pract* 6:611, 1978).

The assumption is made that "Board scores are indicative of cognitive skills related to management of medical problems." Unfortunately, National Board scores

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only test memory, and memory, particularly for complex information, is notoriously volatile. The physician I wish for my family (and the archetypal best physician I urge residents to emulate) is that physician who is thorough, reliable, efficient, and displays analytic sense independent of memory. If this physician does not know a fact with certainty, he or she looks the information up.

In this context, the most disturbing aspect of this paper was the documentation of the failure to recognize no less than 57.8 percent or 583 of 1,008 abnormal results. This profound indictment of our performance when dealing with real people deserves sober reflection. Moreover, this level of performance is far from what we should strive to teach as the model for nascent family physicians.

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Psychologists in Family Medicine

To the Editor:

I would like to inform you of the following information in the hope that it may be of some value to you and to the readers of *The Journal of Family Practice*. There is, currently in the process of rapid development, an organization of *Psychologists in Family Medicine*. PFM is a growing group of psychologists working in family medicine settings—departments of family practice, family medicine residency programs, or with family physicians in private practice. The purpose of the group is to serve as a forum for the exchange of ideas, information, problems, etc. The organization publishes a *Newsletter*. The *Newsletter* is actively soliciting contributions which may be mailed to: Arnold T. Shienvold, PhD, Editor, Psychologists in Family Medicine Newsletter, Department of Family Practice, Harrisburg Hospital, Harrisburg, PA 17101.

Since August 1977, there have been a variety of regional organizational meetings which will culminate in a major organizational session at the 1978 National Convention of the American Psychological Association in Toronto, in August 1978. Additionally, at the APA Convention there will be a symposium consisting of several papers addressing the topic of "Contemporary Issues in Teaching Psychology to Family Practice Residents."

Let me finally add that PFM is also involved with the Medical Psychology Network which is a group of several hundred psychologists involved in various medical settings seeking to organize the field of medical psychology. Further information about the organization may be gained by writing to: Michael J. Asken, PhD, Director, Behavioral Sciences and Medical Psychology, Department of Family Practice, Polyclinic Medical Center, Harrisburg, PA 17105.

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