Editorial

Cost-Containment Teaching With Concurrent Quality Assurance: A Model for Family Practice

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National health expenditures have more than doubled in the last 20 years in the United States and now total almost 11 percent of the gross national product.[1] In 1982 per capita health expenditures in the United States were $1,265 compared with $863 just four years previously and with $386 in Britain in 1982.[2] While the proportion of these expenditures for physicians' services has been stable at about one fifth of total expenditures, the proportion spent on hospital care has steadily increased (now about 40 percent of total costs). Many factors contribute to the escalating costs of health care, including advancing technology, inflation, population growth, patient and physician preferences, the potential threat of malpractice claims, and related factors. Among these, however, it is estimated that physicians in one way or another influence or directly control at least 70 percent of health care expenditures.[3]

Initial interest in the cost problem focused especially on the newer, more complex technologies as the main culprit. More recently the importance of "little ticket" items (especially laboratory tests and x-ray examinations) has been recognized because of their cumulative effect on costs. Regardless of the amount of a particular expenditure, however, an intervention can be cost effective or inflationary depending on whether it is substitutive or additive to other interventions. Thus, computed tomography (CT) scanning has been found to *decrease* the cost of diagnostic evaluation of patients with suspected brain tumor (by eliminating the need for some hospital admissions) while CT scanning has *increased* the cost of care for patients with suspected cerebrovascular accident (ie, no other studies or interventions were replaced).[4,5]

Because of the complexities surrounding the cost issue, the teaching of cost-effective approaches to medical care has proven to be a difficult task. Of particular concern in any effort to cut costs is the need to maintain acceptable levels of quality of care at the same time. It is now becoming increasingly realized that the "more is better" approach to health services has diminishing returns, and that a considerable proportion of hospital days, laboratory and x-ray procedures, and other services can be reduced without compromising patient outcomes. A common difficulty, of course, is that many recommended protocols of "good care" are based upon unproven assumptions. The use of laboratory tests for monitoring purposes is a good example of this problem. One recent study examined physicians' reasons for ordering laboratory tests in a large teaching hospital; one third of these tests were for monitoring purposes, usually unrelated to management decisions.[6]

It has been demonstrated that the higher the level of professional uncertainty or disagreement

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tribution in an emotionally controversial area.

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The Family in Family Medicine

To the Editor:

I am writing in personal response to the article by William T. Merkel, PhD *(The family in family medicine: Should this marriage be saved? J Fam Pract 17:857, 1983).* I am most appreciative of the guest editorial by Christian Ramsey, Jr, MD, in response to this article, in which he outlines some of the many reasons to retain the family as an important basis for family practice.

Family medicine is an eclectic discipline, and this property allows the discipline to evolve and to grow over time. As Dr. Ramsey points out, the family has, in fact, always been a part of the consideration of every family physician or general practitioner, because it is impossible to do this kind of frontline practice without (1) coming to recognize the importance of the family, even when one is dealing with an individual, and (2) developing ways and means for incorporating knowledge of and information concerning the family into one's dealings with that same individual. Removing the family from family medicine would be an impossible task, akin to the task of removing psychoanalytic theory from psychiatry, technology from internal medicine, the theories and techniques of Pasteur and Lister from surgery, etc.

While it is not difficult to counter the arguments and contentions of Dr. Merkel, it is a matter of some concern to me that he articulates a position that does not have a firm basis in reality. Specifically, I wonder whether he has taken an adequate opportunity to work with, observe, and share concepts with physicians, both in the community and in academic settings, and to witness the major efforts being made in family practice education to integrate new concepts of family into a model of practice that clearly meets many of the expectations of the public, individuals, and families.

Family medicine as a discipline is here to stay, the discipline is becoming increasingly sophisticated, the education of family physicians is becoming correspondingly more and more sophisticated, and the family and its impact on the individual and his or her problems will continue to be a major focus both for family practice education and for practicing family physicians.

That clock cannot and will not be turned back, and it is my hope, as an educator in family medicine, that rather than negative polemics, my discipline can continue to engage in fruitful efforts to integrate itself with other disciplines and to incorporate their concepts, attitudes, beliefs, and behaviors into the discipline of family medicine. This is the way in which all of us enrich both ourselves and our prac-

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