Prevention: How to Practice What We Preach

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Prevention works. The regular use of appropriate screening tests, counseling interventions, and immunizations has been shown to reduce morbidity and postpone mortality. Why do some primary care physicians routinely provide these clinical preventive services to their patients, while others do not? Two articles in this issue of the Journal address this question.

Hamblin[1] surveyed 212 Ohio family physicians about their practices in recommending mammography screening. Responding to a series of patient vignettes, physicians were found to vary their recommendation policies depending on the patient and encounter characteristics and the availability and quality of mammograms. Physicians were less likely to recommend mammography to older women; poor women without Medicaid insurance; women who were being seen for acute, rather than health maintenance, visits; and women who had to travel more than 40 miles to have a mammogram. Despite the major limitation of relying on physicians' stated intentions rather than measuring their actual performance, this study provides useful data about barriers to recommendation of screening mammography.

Osborn and colleagues[2] surveyed and audited patient charts of 40 primary care internists and family physicians in northern California. They compared physician demographics and attitudes about cancer screening with documented rates of performance of screening tests for breast, cervical, and colorectal cancer. Women physicians, physicians who stated that they regularly read medical journals, and those who scheduled a higher percentage of periodic health examinations were found to perform more cancer screening tests. Despite the limitation that study physicians were not selected randomly, this research is notable for its use of chart audits to measure actual performance of preventive interventions.

These two studies are examples of, and extensively reference, the increasing number of research articles on prevention found in current primary care journals and conference proceedings. According to the authors' conclusions, most physicians believe that preventive services are important and should be performed regularly, that patients welcome an emphasis on prevention, and that physician delivery of preventive services can be enhanced by practice aids such as flow sheets and reminder systems. So, where do we go from here?

What to Do

Select a set of preventive services. Although there is some disagreement among authorities about which preventive services (especially screening tests) to offer and when, these differences are usually (but not always) at the margins. With the help of a comparative listing of the recommendations of leading authorities,[3] the physician can construct a protocol that is both scientifically sound and appropriate for the patient population and the resources available.

Include counseling and immunizations. In addition to performing appropriate screening tests, it is important to provide immunizations (especially for adults) and counseling for behavioral risk factors. While behavioral interventions may be among the most important interventions available to reduce morbidity and mortality,[4] many studies have shown their rate of delivery to be low.[5] Research has also documented that physicians do an extremely poor job of immunizing adults.[6]

How to Do It

Improve training for prevention. Physicians will not do something they do not feel competent to do. This may explain why internists in the study by Osborn et al[2] were

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less likely to perform pelvic examinations and Papanicolaou smears than family physicians. Physician training at the medical school, residency, and continuing education levels is one key to increasing the performance of preventive services. Osborn et al[2] document that physicians who stated that they keep up with the medical literature performed more cancer screening tests than those who did not. Training must be both in physical examination skills (eg, breast examination and Papanicolaou smear performance) and in counseling techniques (eg, how to counsel on smoking cessation).

Include prevention in every encounter. The US Preventive Services Task Force[4] concluded that preventive services should not be confined to visits dedicated to that purpose. Hamblin's study[1] nicely demonstrated the importance of encounter-related factors in the delivery of clinical preventive services. When time was short, as in a visit for an acute complaint rather than for a periodic health examination, a mammography recommendation was less likely to be offered. Even in an acute care visit on a hectic day, however, there is time for a brief message about a specific preventive measure (eg, the need for smoking cessation) or a short discussion about the need for preventive services in the future.[7]

Stratify patients by risk factors. Performing a constant battery of screening tests on an unselected population of patients is, at best, wasteful and, at worst, dangerous. The US Preventive Services Task Force[4] recommended greater selectivity in the ordering of screening tests for this reason. Hamblin[1] showed that physicians were considering risk factors such as age and family and personal breast cancer history when offering mammography recommendations.

How to Make It Easier to Do

Use a systematic approach to preventive services. Chart flow sheets and computer-generated patient and physician reminders improve adherence to preventive service recommendations.[8] Use of office staff and educational materials improve both the likelihood that screening and other interventions will take place and the effectiveness of the efforts. The US Public Health Service is currently preparing a national preventive services campaign entitled "Put Prevention into Practice" that will provide materials on preventive services for providers, patients, and the office setting.

Improve access to and payment for preventive services. In Hamblin's study,[1] women who were poor and did not have Medicaid were significantly less likely to be referred for a mammogram. Persons without health insurance tend to receive less preventive care than those who have coverage,[9] even though many preventive services are not covered by health insurance. There are some hopeful signs, however, that both public and private sector payers are increasingly recognizing the importance of insuring clinical preventive services, including the recent addition of payment for screening mammography in the Medicare program and the adoption of payment for preventive services by many health maintenance organizations and some indemnity insurers.[10] In addition, one of the overall goals of the recently released national health objectives for the year 2000, "Healthy People 2000," is to achieve access to preventive services for all Americans.[11]

In conclusion, studies such as those in this issue of the Journal are useful to improve understanding of physician characteristics associated with adherence to preventive recommendations. We must also work, however, to improve the educational milieu, the office environment and (perhaps especially) the social and economic system if we are to maximize the gains that can result from putting prevention into practice.

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