I would like to suggest that this proposed strategy is inefficient, costly, and unlikely to be successful. An alternative strategy to offer preventive services during acute care visits will efficiently increase delivery to a greater proportion of patients at a lower cost. This latter strategy has proved to be effective in a single primary care practice[3,4] and is currently being tested in a large community-based multisite, multispecialty group practice.[2] A randomized trial of the competing strategies would also appear to be feasible.

I also agree with Dr. Paul Frame, who stated in an accompanying editorial that "a system for delivering preventive services should be a requirement for accreditation of family practice residency programs."[5]

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The above letter was referred to the first author of the article in question, who offers the following reply.

To the Editor: Dr. Hahn raises a valid issue. Is it feasible to promote visits to primary care offices just for preventive issues? Dr. Hahn has written that it is not feasible and still have time to care for sick patients.[1] This conclusion was arrived at by assuming that each primary care physician would spend 30 additional minutes each year performing a complete physical examination for approximately 54,000 patients currently seen for acute care. This conclusion, however, has several assumptions. The first is that the acute care visits would remain the same. There is no evidence to support this assumption, and many have hypothesized that acute care visits would decrease. The second is that a complete physical examination is preventive service. On the contrary, preventive services are not complete physical examinations; a complete physical examination has not proved to be an effective preventive service. Third, one appointment for preventive services might be enough to facilitate the delivery of preventive services in future acute care visits. The literature has reported that ever having been seen for a health maintenance examination is predictive of getting preventive services and being current. So, it might take only one such visit to implement a system that can address preventive services at other contacts.

All of us who struggle in the field of increasing the delivery of preventive services must be cautious with our interpretation of the published data. The literature has many examples of interventions that made significant changes—in one office,[2–5] in academic settings,[6,7] when focused on one specific preventive service,[8–10] or within a short period of time. In contrast, the large randomized controlled trials of theoretically sound interventions have shown no effects to minimal changes in the delivery of preventive services in community-based primary care offices across several years.[11–13] This was recently reconfirmed at the annual meeting of the North American Primary Care Research Group. Four presentations focused on randomized clinical trials of different interventions to increase the delivery of preventive services. All reported no effect to minimal increases. All the published and presented studies have not been trying to increase office visits solely for preventive services. All have taken the approach of increasing the delivery of preventive services at all encounters.

With these failures, I conclude it is time for some radical reexamination of preventive services and changing primary care practices. From this perspective, one questions Dr. Hahn's conclusions that it is not feasible to promote encounters only for preventive services. It might actually decrease acute care visits and increase preventive services. Dr. Hahn's limited trial warrants replication in larger settings for a longer period. In addition, our understanding of the black box of practice behavior and changing practice behaviors is in the infancy stage. There is a need for more basic research into the variables that contribute to the behaviors of a community-based primary care practice. This information will guide the next generation of interventions. I agree with Dr. Frame, it is time for residency accreditation agencies and practicing physician certification groups to focus on measures of health status among the populations served by family physicians of which preventive services delivered is critical.

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