COMMENTARY

Guest Family Physician Commentaries

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Re: Physician Specialty and the Quality of Medical Care Experiences in the Context of the Taiwan National Health Insurance System[1]

It only makes sense that primary care would score higher on an instrument "organized around the principles of primary care." Putting "excluded community-based doctors" back into the study might make the results even stronger. However, patient satisfaction is not the issue for practicing family physicians. The problem is, rather, the disparity between levels of reimbursement for services that reward specialty care and that underpay family physicians. Young medical school graduates cannot select a primary care specialty if they will be unable to pay back their education loans and earn a decent living when starting their careers. I have nothing against the high-quality services surgical specialists provide because they are also essential for good care, but until the reimbursement system is fixed to equalize pay between family physicians and the surgical subspecialties, the quality of patient-centered primary care provided by family physicians that people want will continue to dwindle as our numbers decrease. Turning to nurse practitioners and physician assistants as cost-saving replacements for primary care doctors is not a very good long-term solution. Perhaps patient demand for good, accessible, comprehensive primary care delivered in a personal setting will again rescue family physicians from the extinction the health care system in the United States has assigned to us.

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Re: Perceived Benefit of Complementary and Alternative Medicine (CAM) for Back Pain: A National Survey[2]

Almost any therapy that provides a measure of immediate comfort and eventual relief will work for the first few weeks of treatment of lumbar back pain. At this early stage of treatment, the issue for clinicians and sufferers is selecting a modality that does no harm and provides maximal individual benefit at a low cost. Many complementary and alternative medicine (CAM) therapies fit these criteria and should be utilized by family physicians, but some of them may not be available in all rural areas of the country. A bigger issue for clinicians is sorting out the diagnosis and relieving pain that, after the first few weeks, does not respond to initial conservative therapy. Future studies should focus on the treatment of this second area of subacute and chronic back pain. Psychological issues, disabilities, and life circumstances need to be assessed and controlled for in back pain research. Whether the episode of back pain is an initial experience, a recurrent problem, a new episode after a history of lumbar back surgery, or involves another complicating factor is critical in measuring response to treatment and should be considered as different categories.

Although subjective reports of patient satisfaction with their treatment are important, objective data from prospective trials of CAM therapies are also needed to aid in decision making. Studies directly comparing CAM therapies—such as acupuncture, massage therapy, spinal manipulation, yoga, and qi gong exercises—with standard pharmacological treatments, physical therapy, and epidural steroid injection for subacute and chronic low back pain would help guide selection of treatment modalities when treatment is required beyond the initial 2 weeks. According to the Cochrane Reviews, these issues are far from settled. Cost-benefit data for each modality showing charges for the complete course of each therapy compared with the cost of days of work lost and disability payments

saved would be helpful. The large burden that low back pain presents for primary care certainly warrants further study.

Re: The Law of Diminishing Returns in Clinical Medicine: How Much Risk Reduction is Enough?[3]

The law of diminishing returns is an important concept to keep in mind as we face a new era of restricted resources and rapidly expanding technology. Family physicians have always accepted a certain level of uncertainty and have assumed the substantial daily risk required to manage the broad range of conditions and patients that present to us with the limited time and resources we currently have. We all want each patient to have the best possible outcome, so it is difficult to deny expensive testing when the patient requests it and when your liability is higher for denying it if your choice is wrong. The "gate-keeper" concept as a mechanism for denial of care is already a failed experiment. It takes a lot of time to explain to patients why the generic medicine they are currently on is better for them than some expensive drug they have recently seen advertised on television. We now face even more limitations in the number of options available, both in selecting the minimum effective diagnostic procedures necessary and limiting the therapeutic modalities to the smallest, most effective number. Nothing is as simple as it seems—combining some therapies, as in the example of Mr. Martin, is not even additive whereas in other situations some combinations are synergistic.

Of course, all of this theory is based on mathematical percentages, which are difficult to apply to an individual patient. Even though statistically the first 3 interventions reduced Mr. Martin's risk by 93%, how can a clinician ignore an A1c of 10? Or, what if his low-density lipoprotein cholesterol was 200 or higher? Would you want these factors ignored if you knew you had a strong family history of coronary artery disease? If these changes are entered into his Archimedes profile to evaluate their further effect, each option takes several minutes to process individually. Do busy family physicians have this kind of time or ancillary support in the standard office setting? Or, until more comparative effectiveness research is available, are such exercises more appropriate for the academic setting? However, the goal of reducing intervention to the lowest effective denominator is still a good one for which to aim.

References

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