

COMMENTARY

Guest Family Physician Commentaries

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Re: Having a Personal Health Care Provider and Receipt of Adequate Cervical and Breast Cancer Screening

What if you could develop a system which (1) was proven to improve health care outcomes and life-span for patients, especially those who are the most vulnerable; (2) reduced human suffering; and (3) provided early detection of several of the more common types of cancer in women? Would you believe this system is already in place? Cardarelli et al,¹ in their article titled “Having a Personal Health Care Provider and Receipt of Adequate Cervical and Breast Cancer Screening” in this issue of the *Journal of the American Board of Family Medicine*, succinctly lay out specific and persuasive evidence to make the case that a relationship with a personal health care provider is an important determinant of who receives adequate breast and cervical cancer screening. If one accepts the scientifically supported premise that more adequate screenings translate to better health outcomes and lives saved, then this article establishes much more than just showing that personal health care relationships are important mediators of patient behavior. In fact, if the previous premise is true, personal health care relationships save lives.

Despite major advances in medical science and technology, American-styled health care has seemingly ignored the “elephant in the room.” This “elephant” is none other than the disparity of care

in the United States that occurs at a very basic level. This disparity seems to stem, at least in part, to the patients’ lack of identification and relationship with a personal physician or health care provider. Basic examinations and common medical procedures performed or ordered by competently practicing “specialists in generalist care” (ie, primary care physicians and personal health care providers) are capable of detecting a majority of health problems; however, the lack of identification with a personal health care provider seems to be at least part of the reason that some patients experience poorer health outcomes with regard to early detection and proper screening for breast cancer and cervical cancer. After reading this article, it is abundantly apparent that a relationship with a personal physician or health care provider is essential in achieving more complete comprehensive care and screening for breast and cervical cancers.

Moreover, the article reinforces several important maxims understood by almost every other industrialized health care system: “at its essence medicine is simply that relationship that exists between a patient and personal physician” and that “as goes primary care, so goes medicine.” Understanding health care delivery as a relational event that drives actual outcome and quality measures is an idea upheld by this article and its authors.

Re: Physician Supply and Breast Cancer Survival

As the United States grapples with the issue of health care reform and the possibility of some permutation of universal care, including the provision of a single-payer system, this new study out of Canada² illustrates that the presence of adequate primary care may be one of the most important variables for determining the success of health quality outcomes for a population. Although it should be acknowledged that this study was conducted in a country with a fairly homogenous health care system that provides universal coverage for its citizens, it is interesting to note that specific

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densities of primary care providers (specifically family physicians and physicians practicing obstetrics/gynecology) was found to be a significant independent determinant of 5-year breast cancer survival. This article has significant relevance to the practicing physician because it supports several important arguments in favor of a comprehensive primary care system.

First, frequently the preventive care advocacy movements are forced to defend that preventative care is beneficial and essential to the success of a health care system. Although much of this rhetoric stems from strict models of economic utilitarianism and rigid philosophies of what the definition of optimal health care should be, this article again illustrates that the density of primary care physicians (ie, family physicians in excess of 7.25 per 10,000 persons and physicians practicing obstetrics/gynecology in excess of 6 per 100,000 persons)—at least in one Canadian province—is a significant independent predictor of 5-year breast cancer survival among women, irrespective of locale, socio-economic status, local healthcare resources, specialty care, and other factors.

Second, when the density of primary care providers fell below the thresholds mentioned above, breast cancer survivability—and hence a woman's risk of dying from breast cancer—increased. That drops in these densities can be traced to periods when pay for Canadian physicians and the numbers of retained primary care physicians in Canada fell below the threshold densities is interesting because it indicates that physician compensation and retention, at least regionally in Canada, is tied to improved patient outcomes. As Canadian primary care densities once again increase because of enhanced reimbursement structures and an educational emphasis on primary care, it will be interesting to study whether this further enhances 5-year survival rates for women with breast cancer in these same locales. Regardless, for anyone involved in making policy, this article again provides important evidence that the density of primary care physicians up to and in excess of certain thresholds per patient population, and the retention of primary care providers (family medicine physicians and obstetricians/gynecologists) are very important determinants of 5-year breast cancer survivability. Exploring other disease-specific areas where primary care improves survival remains an important and necessary research objective for primary care.

This is a timely and relevant article for all primary care physicians and especially those involved in policy discussions regarding health care reform.

Re: Does Having a Personal Physician Improve Quality of Care in Diabetes?

This small, population-based, prospective, 3-year study³ found some marginal benefits in favor of the utilization of empanelment of patients with type 2 diabetes to a personal physician. Overall, the study found that those patients with a personal care physician had a better glycosylated hemoglobin (A1C), although A1C management was similar. Having a personal care physician also showed significant benefits in terms of who received an influenza vaccine but having a personal care physician in this study did not significantly affect who had received a pneumococcal vaccine, who had adequate low-density lipoprotein cholesterol control, who had adequate blood pressure control, or which patients had appropriate aspirin use.

The study was limited to patients aged 18 to 75 with a diagnosis of type 2 diabetes mellitus (DM) who were seen between 2005 and 2008 at an academic family medicine facility in South Carolina and who had a minimum of 2 visits during this period and a diagnosis of type 2 DM for at least 6 months. The practice in the study had a continuous electronic medical record functioning before, during, and after the study and consisted of 24 full-time practicing family medicine faculty as well as students and residents. This resulted in a population density of physicians to patients with type 2 DM within the practice—irrespective of medical students, residents, or other clinical treatment support systems—of approximately 1 physician per 30.6 patients (assigned and unassigned type 2 DM populations) or 1 physician to 27.83 patients (assigned type 2 DM populations). The small ratio of unassigned patients ($n = 68$) versus assigned patients ($n = 668$) was noted as an asymmetrical aspect of this study, and physicians identified the patients for whom they considered themselves to be the personal provider (ie, patients did not identify the physician whom they considered their personal provider).

Furthermore, a potential confounding variable—the presence of an urgent care facility, which was acknowledged within the study to be the place where many of the patients chose to receive their

care—may have impacted the effectiveness of the empanelled patient-provider relationship to provide superior health outcomes. In addition, allowing inclusion within the study of those patients with 2 visits within a 3-year period seems to illustrate that routine structured care may have been underutilized in this particular clinical setting. Structured care (ie, planned care) has now been shown to be superior in terms of quality outcome measures in a variety of settings and the use of the emergency department and its convenience has seemed to cause reductions in quality in these health outcomes. This is another issue to keep in mind when considering this data. In other words, it would seem that the type of care that works best from a quality perspective is care the patient needs when they need it, not care the patient wants when they want it. Nevertheless, this study does indicate that the benefits of having a personal physician may be

trumped by simply having a system that delivers consistent, measurable, outcome-based care across the spectrum of patients. Furthermore, physician-to-patient ratios, such as those within these studies, are likely to be financially unsustainable and therefore not realistic in terms of real-world management of most type 2 DM population. Expanded studies in this area are needed to guide optimal system design.

References

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