COMMENTARY

Guest Family Physician Commentaries

Paul Hicks, MD, MSHCM (J Am Board Fam Med 2011;24:226–228.)

Doing Things Right and Doing the Right Thing in Patient-Centered Care

Reading this issue of *The Journal of the American Board of Family Medicine*, I was reminded of the management guru Peter Drucker's quote: "Management is doing things right; leadership is doing the right things." Medicine seems to be a bit of both. Doing things right could be translated as increasing preventive care, practicing according to evidence-based guidelines, and improving patient and provider education to maximize outcomes for our patients. Doing the right things seems to apply well to the relationships we build in medicine between doctor and patient that serve as the foundation on which our medical interventions succeed or fail.

Addressing the latter, Bertakis and Azari[1] evaluated the impact that patient-centered care has on health care utilization. Following 509 newly enrolled adult patients in residency clinics over a period of 1 year, they found interactions with higher rates of patient-centered communication were associated with lower utilization of health services in nearly all traditional venues: primary care, specialty care, emergency department use, and hospitalization.

Previous literature has suggested different specialties have different styles of communication,[2] and those differences may lead to changes in outcomes for our patients.[3] This seems to be true both for hard outcomes, such as health care utilization seen here and elsewhere,[4,5] as well as more soft outcomes of patient trust and physician connectedness.[5-7] Limitations in this current study include lack of evaluation of noneconomic/utilization outcomes or longer-term outcomes relating to health and wellness, as well as that it is based on a 20-year old data set. Repeating this study in our current culture and with the current generation of physicians—who may or may not be more acculturated into this communication style—as well as looking at clinically relevant outcomes would be helpful.

Separately in this issue, a study by Bender and colleagues[8] provides something of a bridge with Peter Drucker's concepts. Looking at rural communities in Colorado, Bender et al[8] provided intensive education on asthma treatment to medical providers and their practices. This intervention involved one full day and 2 half-days of onsite training sessions for physicians and staff, provision of Provider Asthma Toolkits, and a free spirometer to participating practices. With such intensive intervention, there was a measurable uptick in overall guideline adherence for medication management, symptom-directed therapy, and spirometry use.

Interestingly, the intervention could also be seen in a relational perspective. From a reader's perspective it seems that the efforts of the program were dependent on the success of the relationship with the trainers on one hand and the providers and staff on the other; in a way it redefined the trainer as the physician and the practices as the patients. It is remarkable to see that Bender's group found similar ratios of effectiveness with their intervention that we see with so many interventions in our own patients.[9] In this study, Bender and colleagues[8] found that about a third of practices were already practicing according to evidence-based guidelines, a third were motivated by the training, and the last third were less engaged. Statistically, then, though the intervention was successful overall, in the first group the intervention was unnecessary and did not change behavior. In the last group, behavior also did not change. Only in the motivated third was behavior significantly modified. If research could help providers identify the factors that predict acceptance and behavior change among practices and

From the University of Arizona Department of Family and Community Medicine, Tucson.
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Corresponding author: Paul Hicks, MD, University of Arizona Department of Family and Community Medicine, 1450 North Cherry Avenue, Tucson, AZ 85719, (E-mail: phicks@uph.org).

our patients, we could better tailor our interventions to the appropriate audiences.

The final 2 studies, both by Tiemstra and colleagues,[10,11] look at doing things right in the form of preventive care. Both studies evaluate the effect of Papanicolaou testing on subsequent genitourinary symptoms. In the first study,[10] they looked at 153 patients presenting for routine Papanicolaou testing, excluding those patients with pre-existing urinary symptoms. They found 2 main issues: (1) 1 in 6 women has dysuria, urinary frequency, or both in any given month; and (2) getting a Papanicolaou test nearly doubles that risk (from 17% to 32% in those who had Papanicolaou test).

In a follow up study,[11] Tiemstra's group evaluated 1582 women who had Papanicolaou testing at any time and their rates of urinary tract infections (UTIs) during the next year. They found that within the first 7 weeks after a Papanicolaou test, UTIs occurred at a rate of 12.7 per 100 person years versus 6.51 per 100 person-years in the subsequent 45 weeks. The mechanism might be through microtrauma to the mucosa from the placement of the speculum, with introduction of bacteria into the urethra. Given the relatively low inoculum rates during the Papanicolaou test, it is presumed to take a few weeks for symptoms to become bothersome.

In these studies we see the unintended consequences of our well-meaning efforts to maximize our preventive measures and decrease cervical cancer rates. Just the performance of that test, though, gives a number needed to harm of 6.67 and doubles the risk of UTI over the next 2 months. Paying attention to the *right things*, that is, maintaining our focus on a comprehensive picture of patient wellness rather than doing the same thing at higher rates, calls us to do something different. It may lead us as a specialty to adopt more rapidly the newly revised American College of Obstetricians and Gynecologists recommendations[12,13] for less frequent Papanicolaou screening. Or we may opt to abandon physician-collected Papanicolaou smears entirely. As an alternative, there is emerging data to support the use of patient self-collected swabs for human papillomavirus as being of sufficient sensitivity and higher patient-acceptability than physician-collected Papanicolaou smears.[14-16] Used frequently in the developing world,[17] there is a study to be completed in the autumn of 2011 that evaluates this strategy among Canadian women.[18] Depending on those findings, self-collected swabs may be the practice of the future, making us more patient-centered both in how we speak to our patients and in what we do to and for them. Ultimately, we need to keep our focus on doing the *right thing*, not just the usual thing, for our patients.

References

1. Bertakis KD, Azari R. Patient-centered care is associated with decreased healthcare utilization. J Am Board Fam Med 2011;24:229–239.
2. Bertakis KD, Robbins JA, Callahan EJ, Helms LJ, Azari R. Physician practice style patterns with established patients: determinants and differences between family practice and general internal medicine residents. Fam Med 1999;31(3):187–94.
3. Mead N, Bower P. Patient-centered consultations and outcomes in primary care: A review of the literature. Patient Educ Couns 2002;48:51–61.
4. Epstein RM, Franks P, Shields CG, et al. Patient-centered communication and diagnostic testing. Ann Fam Med 2005;3(5):415–21.
5. Stewart M, Brown JB, Donner A, et al. The impact of patient-centered care on outcomes. J Fam Pract 2000;49(9):796–804.
6. Fiscella K, Meldrum S, Franks P, et al. Patient trust: is it related to patient-centered behavior of primary care physicians? Med Care 2004;42(11):1049–55.
7. Henbest RJ, Stewart M. Patient-centredness in the consultation. 2: Does it really make a difference? Fam Pract 1990;7(1):28–33.
8. Bender BG, Dickinson P, Rankin A, Wamboldt FS, Zittleman L, Westfall JM. The Colorado asthma toolkit program: a practice coaching intervention from the High Plains Research Network. J Am Board Fam Med 2011;24:240–248.
9. Hicks PC, Westfall JM, Van Vorst RF, et al. Action or inaction? Decision making in patients with diabetes and elevated blood pressure in primary care. Diabetes Care 2006;29(12):2580–5.
10. Tiemstra JD, Pela E. Urinary symptoms after a routine pelvic exam. J Am Board Fam Med 2011;24:290–295.
11. Tiemstra JD, Chico PD, Pela E. Genitourinary infections after a routine pelvic exam. J Am Board Fam Med. 2011;24:296–303.
12. ACOG Committee on Practice Bulletins–Gynecology. ACOG practice bulletin no. 109: cervical cytology screening. Obstet Gynecol 2009;114(6):1409–20.
13. ACOG Committee on Gynecological Practice. ACOG committee opinion no. 431: routine pelvic examination and cervical cytology screening. Obstet Gynecol 2009;113(5):1190–3.
14. Wright TC Jr, Denny L, Kuhn L, Pollack A, Lorincz A. HPV DNA testing of self-collected vaginal samples compared with cytologic screening to detect cervical cancer. JAMA 2000;283(1):81–6.

15. Sellors JW, Lorincz AT, Mahony JB, et al. Comparison of self-collected vaginal, vulvar and urine samples with physician-collected cervical samples for human papillomavirus testing to detect high-grade squamous intraepithelial lesions. CMAJ 2000;163(5):513–8.
16. Dzuba IG, Díaz EY, Allen B, et al. The acceptability of self-collected samples for HPV testing vs. the pap test as alternatives in cervical cancer screening. J Womens Health Gend Based Med 2002;11(3):265–75.
17. Bhatla N, Dar L, Patro AR, et al. Can human papillomavirus DNA testing of self-collected vaginal samples compare with physician-collected cervical samples and cytology for cervical cancer screening in developing countries? Cancer Epidemiol 2009;33(6):446–50.
18. National Institutes of Health. Randomize trial of vaginal self sampling for human papillomavirus (HPV). Available at: http://clinicaltrials.gov/ct2/show/NCT01095198?term=NCT01095198&rank=1. Accessed 12 February 2011.