

Reflections in Family Practice

Family Physicians As Proceduralists: Striking A Balance

Howard Brody, MD, PhD, and Gregory P. Alexander, MD

Currently family physicians might find themselves conflicted about performing various diagnostic and therapeutic procedures, which as a rule are handsomely reimbursed.¹⁻³ On the one hand, family physicians are trying to distinguish their specialty from the practice of others and to be proud of what is unique to family medicine. Often a distinction that appears easy to grasp is the relatively more frequent use of "high-tech" procedures by other specialists. The family physician tends to equate high-quality practice with a less costly and often more elegant "low-tech, high-touch" approach in which the physician relies much more on the diagnostic and therapeutic skills that accompany long-standing relationships with patients and careful attention to the patient's psychosocial environment.

On the other hand, in today's practice environment, physicians are often reimbursed for procedures far out of proportion to the time, energy, and skill required to perform them. Given the generally low rate of reimbursement for primary care services, it would seem no more than just for the family physician to make use of several procedures as "moneymakers" for the practice. This approach, of course, challenges some of the concepts of what is unique to family medicine just elaborated. We might look askance upon our obstetrician colleague who orders a sonogram at every prenatal visit, apparently for no better reason than that our colleague owns the machine and can bill for each test. But if we have just been to a workshop on flexible sigmoidoscopy and are

now overwhelmed with a passion to talk every one of our patients into having sigmoidoscopy as an annual screening procedure, then our criticisms might appear to be emanating from an undeniably glass house. (A recent review of physicians' later use of sigmoidoscopy skills learned in residency measured number of procedures performed in relation to the extent of training, but was totally silent on whether they knew how to assess either the quality or the appropriateness of the sigmoidoscopies they performed.⁴)

The proper place for procedures in family practice requires, therefore, a careful balancing among competing values. When debated at all, this issue is commonly addressed in terms of appropriateness or competence, but when numerous values are in potential conflict, the issue can accurately be described as an ethical one. Discussions of ethical issues in primary care seldom address procedures explicitly, however, and this reticence might in part be related to physicians' general unwillingness to address explicitly, as an ethical issue, anything that directly impacts upon their incomes.⁵ In this article we attempt to redress this gap by discussing some of the ethical ramifications of procedures in family practice.

To focus upon the points of greatest ethical concern, we will limit our discussion. We will take for granted that family physicians can in fact be trained to perform competently a wide variety of procedures including, but hardly limited to, endoscopy, colposcopy, vasectomy, skin surgery, and interpretation of radiographs and electrocardiograms. (Indeed, it has recently been demonstrated that nurses can perform screening sigmoidoscopies as proficiently as gastroenterologists.⁶) A review of the extensive literature upon the history and politics of procedures and privileges, as well as the statements and guidelines of various specialty organizations, is beyond the scope of this paper.

Proceduralist: Support

It might be helpful to begin this discussion by reviewing the competing arguments in the form of

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From the Division of Primary Care, Agency for Health Care Policy and Research, Rockville, MD; and the Department of Family Practice, Michigan State University, East Lansing. Address reprint requests to Howard Brody, MD, Department of Family Practice, B-100 Clinical Center, Michigan State University, East Lansing, MI 48824.

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a debate. First, we will look at those considerations that support the role of the family physician as a proceduralist.

One reason for doing procedures focuses upon solidarity within the specialty of family medicine. Our history reveals numerous instances of family physicians being denied privileges to perform procedures for which they were fully trained and qualified, merely because of turf battles with other specialties. The proper response to these limitations placed upon our practices, it can be argued, is to resist any such limits in the future and assure that family physicians have full opportunities to practice anything that they learn to do properly. It might seem that for us, internally, to try to limit our performance of procedures is in effect caving in to those outside forces that would limit our specialty's scope of practice for their own ends.

There is, moreover, a special sort of satisfaction that procedures provide in our daily work. A great deal of family practice leads to undeniable payoffs and successes, but those results are sometimes far in the future and invisible to the physician toiling in the office trying to make it through today's schedule. A procedure competently performed, on the other hand, provides an immediate and tangible gratification. Day-to-day morale could easily suffer from too readily dispensing with this part of our practice.

Other reasons focus on the needs of our patients. If we form long-standing and personal relationships with our patients, they naturally will want to come to our offices, not someone else's, when simple procedures need to be performed, and they will appreciate both the convenience and the reassurance of a familiar site close to home. If we fail to learn to perform simple office procedures competently, we deprive our patients of these benefits. In some extreme cases, not being able to do a procedure (such as vaginal delivery) could arguably undermine our claims to providing true continuity of care for the entire family unit.

Economic arguments are often used to defend the role of the family physician as proceduralist. Family medicine services generally are compensated at an inappropriately low rate.⁷ By contrast, reimbursement for procedures can be generous compared with the time spent doing them. If, accordingly, the family physician can readily supple-

ment personal income by doing a number of procedures, doing so can be seen as nothing more than redressing a previous inequity.

A final reason addresses the intellectual vibrancy of family practice. One of the strengths of the field is that it is so broad that individual physicians can subspecialize in areas particularly intriguing to them without losing their identities as true family physicians or being tempted to give up family medicine for some other specialty. Such is true, for example, of family physicians who have especially trained in and devote considerable amounts of time to geriatrics or sports medicine, without giving up general family medicine. These physicians, arguably, strengthen the specialty by the special intellectual edge they bring. Learning procedures is another way that the individual family physician can contribute to this advancement of the field, which, among other things, might cause medical students to look more favorably upon a career in family practice.

Proceduralist: Objections

Whereas the reasons supporting the use of procedures in family practice are impressive, several objections can also be lodged. One major objection is the assertion that physicians who do procedures often do so with an eye toward increasing income. When money is at stake, physicians are more prone to a self-deception that ultimately undermines their ability to assess objectively the quality of their care — they might be tempted to fudge on how qualified they are to do the procedure in riskier cases or how much a particular patient actually needs the procedure. (For instance, one published case report, in a family practice journal, of colon perforation following flexible sigmoidoscopy in an asymptomatic, elderly female totally ignored the obvious question of whether the procedure was truly indicated to begin with.⁸) Although the term *self-referral* is most often used when a physician sends a patient to an outside laboratory or diagnostic facility in which he or she owns a financial stake, procedures performed by family physicians are in actuality a version of self-referral and thus raise the same ethical questions of financial conflicts of interest. If family physicians are unfairly undercompensated for nonprocedural services, the solution is physician payment reform rather than overreliance on procedures to make up income.

This objection does not disappear if, in the future, medical reimbursement is reformed to eliminate the undue weight now placed upon procedures. If, as seems likely, reform leads to greater reliance on managed care as a means of containing cost, managed-care organizations will likely encourage primary care physicians on their staff or in their system to perform procedures as a way of avoiding having to pay for the higher cost services of other specialists (or of limiting the number of those specialists they need to have on staff or under contract). Thus, in a reformed system financial pressures might be less apt to encourage unnecessary procedures, but might instead encourage family physicians to perform procedures upon patients with more complicated problems who in an optimal system might have been referred elsewhere.

Motives other than financial might drive family physicians toward inappropriate overuse of procedures. According to Scherger,³ epidemiologic calculations suggest that the population of patients making up the average physician's practice requires a frequency of procedures well below the minimum frequency for maintaining proficiency. Thus a physician might feel driven to do more procedures than were really needed by the patients simply as a way of keeping up hard-earned skills.

Another objection assumes a direct competition between the proceduralist and the generalist roles of the family physician. Doing procedures can be fun and challenging, but in the end it undermines what is special about family practice, which is its so-called "low-tech, high-touch" approach. In particular, residents in training are often eager to learn procedures, and their teachers might fear that the residents will become enamored of the purely technical side of medicine before they have had sufficient clinical experience to see that technical side in its proper perspective; at worst, residents will devote the time and energy to learning to use machines that they should have been devoting to perfecting their eyes, ears, and interpersonal skills. That mode of training would seem to prepare the next generation of family physicians poorly for the role they will be expected to fill.

A final objection, closely related to the previous two, is that family physicians are now one of the few groups of internal critics within medicine

who can call for a more cost-effective and patient-centered mode of practice and who can effectively reveal the inadequacies and fallacies of the dominant high-tech and high-cost mode of subspecialized care in US medicine. Family practice, by this argument, is a counterculture that has responsibilities for reforming the rest of medicine.⁹ By getting our hands dirty when we are seduced by the lure of procedures, we forfeit our golden opportunity as internal critics.

Ethical Balance

The above debate suggests that we cannot ethically dismiss procedures in family practice, nor can we assume that we can encourage procedures and all will automatically be well. Instead, we must seek some way of balancing the competing values in everyday practice settings.

One way of approaching the task of balance is part and parcel of good family medicine, which is to embrace the dictates of evidence-based medicine and expect of ourselves a more explicit account of what medical interventions are indicated in what circumstances. Our specialty can work to develop more explicit guidelines on how many and what sorts of procedures family physicians must do to be competent to perform them at various levels of patient complexity and when certain procedures are truly in the patient's interest. We can then secure the cooperation of larger practice organizations to implement various modes of internal quality audits, designed by ourselves to take into account the realities and limitations of our usual mode of office practice, so that we get data that are truly useful and informative in the most user-friendly manner possible. When we show this level of responsibility and accountability, we will be immune from any possible criticism that we are doing more procedures merely to make more money. We will also be in the strongest possible position to suggest to our subspecialist colleagues that they should also practice in this fashion.

Another way to achieve balance is to become more future oriented and think in terms of group rather than solo practice. Where family physicians already practice in groups, it is common for particular physicians to specialize in one or two procedures and for the other physicians in the group to refer patients needing that procedure to that practitioner. This practice assures that pa-

tients can receive the services in the same office (if not always from the same provider), that there is some degree of quality assurance which comes from looking over each other's shoulders, and that each physician stays proficient by doing a lot of one or two procedures rather than doing a few of many. As a group the family practice does many procedures; but no one physician has become so exclusively a proceduralist as to threaten his or her identity as a true family practitioner.

When this sort of group practice joins a managed-care plan, there is generally no problem in providing good patient care at a reasonable cost. Because these procedures do not have to be performed out of the office, the managers are pleased with the lower rate of expensive referrals.

One could argue that in the future, all family practice should occur in such relatively large groups. If, however, we assume that 1-, 2-, or 3-physician offices will still be a part of our specialty for the foreseeable future, then we need to ask how these smaller office sites can network with each other to achieve some of the same advantages of the larger groups. There is no reason why 6 or 8 solo practitioners, for instance, could not network themselves as a group based on a balance of procedural skills among them, so that they agree to send all the colonoscopies to Dr. A, all the sigmoidoscopies to Dr. B, and so on. Admittedly, patients would have to go to a different office site for some procedures, but at least they are guaranteed they will encounter a physician and an office staff who all practice according to the same values and goals as their trusted family physician. If these physicians all belong to the same managed-care plan, they should be able to negotiate a method of regarding these lateral procedure referrals as distinct from referrals to other specialists and so represent an overall cost-saving for the plan. Moreover, the plan can work with the various office sites to implement an effective and nonburdensome quality-assurance structure.

Recommendations

We conclude that a wide variety of procedures can be ethically performed as part of the role of the generalist family physician but that maintaining high ethical standards requires explicit attention to a number of features of practice which

currently are being ignored. The following recommendations might assist in striking the correct balance:

1. We should continue to train family physicians to discern the appropriate indications for and to perform a variety of procedures. We should also assure that residency training and continuing medical education never overemphasize procedural skills to the neglect of interpersonal and patient care skills.
2. The specialty should develop data systems for office practice to assure that unnecessary and inappropriate procedures are easily detected and that periodic assessments of outcomes and complications are facilitated.
3. Family physicians contracting with managed-care organizations or practice networks should insist that financial support for these data systems be provided as part of the basic cost of quality improvement.
4. Family physicians should assure that, to the extent that they have control over fee-setting, reimbursements for procedures reasonably reflect time, effort, and equipment investments and are not unduly inflated.

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