

# Provocative Questions

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Participants in the TRACK discussion raise provocative new questions about articles published in the fourth issue of the *Annals* while continuing the dialogue about continuity of care from our previous issue. In addition to summarizing these discussions, this On TRACK raises additional questions prompted by the online conversation. We invite you to join this ongoing discussion with answers to the italicized questions below, or with questions or comments of your own. Log on to <http://www.annfammed.org> and click on "Discussion of articles."

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## THE PATIENT'S PERSPECTIVE IN MAKING SENSE OF ABNORMAL PAP RESULTS

Candib,<sup>1</sup> viewed the study by Karasz et al<sup>2</sup> as a challenge to pay more attention to patients' concerns and our communication. "This work challenges us to scrutinize our own systems for giving patients abnormal results and to reexamine how we personally explain Pap smear results and explore patients' concerns."

*As a clinician, how could a shift toward greater consideration of the patient's explanatory models and understanding of the meaning of Pap results change your practice?*

*As a patient, does the study by Karasz and colleagues resonate with your experience? Do you want your clinician to take the kind of action described by Dr. Candib?*

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## THE RELATIONSHIP CONTEXT AND PATIENT ACCEPTANCE OF RISK-BASED SCREENING

Pace's personal experience in talking with women in his 20-year continuity practice<sup>3</sup> gives him a different perspective than was found in the study by Smith et al.<sup>4</sup> Smith and colleagues found great reluctance to engage in risk-based cervical cancer screening. Women's stories about their need for self-advocacy seem to be at odds with Dr. Pace's experience of a high level of patient acceptance of longer screening intervals.

*How does a trusting relationship with a clinician affect the patient's personal experience that seems so important in acceptance of risk-based screening?*

*How do the health care system context and trust affect women's perception of risk-based screening?*

Harper et al<sup>5</sup> quote recent data showing the benefit of longer intervals between cervical cancer screenings. They present their own data showing that among women's ranking of 22 reasons for an annual examination, having a Pap smear ranked number 8—lower than 5 reasons that relate to the clinician-patient relationship. They raise the provocative hypothesis that "interval screening may be limited not by the frequency of the woman's visit to her provider, but by the physician's ability to change his/her screening behaviors."

*How much does the Pap smear influence the decision of women and the recommendations of their clinicians about how often to engage in well-person care? How can the complex issues around risk-based screening be better understood? How can communication around this issue be improved?*

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## RATIONING BY SOCIAL STATUS

The need for a more rational way of thinking about and allocating screening is proclaimed by Woolf.<sup>6</sup> He frames the findings by Smith et al<sup>4</sup> as part of "the ingrained perception of Americans that screening tests are inherently beneficial." Dr. Woolf draws parallels between the qualitative study by Smith and colleagues and the epidemiological study by Østbye et al.<sup>7</sup> He interprets the epidemiological data on breast and cervical cancer screening among the elderly as probably representing some degree of overscreening. He points out that lower rates of screening among the poor and poorly educated represent rationing by social status. "Unlike in European society, Americans are reluctant to reduce access to achieve equity."

*How do we move forward with prioritizing and delivering the most effective health care for all, considering "the ingrained perception of Americans that screening tests are inherently beneficial?"<sup>6</sup>*

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## CHAPERONES—FOR WHOSE BENEFIT?

The study by Rockwell et al<sup>8</sup> elicited personal experiences that support the need for a chaperone,<sup>9</sup> as well as contrasting views about the effect of chaperones on office efficiency.<sup>10,11</sup> Silverberg<sup>12</sup> calls for more research to answer related and broader questions about the role

of chaperones, and calls for their use to be a shared decision between patients and clinicians.

*What are the needs of clinicians that are potentially met by the presence of a chaperone in a wide variety of situations? What needs of patients are met by a chaperone? What shared needs?*<sup>13</sup>

*To what extent is the use of chaperones related to malpractice claim rates?*<sup>13,14</sup>

*How can creative redesign of the role of office staff members fill the chaperone role while increasing the efficiency and effectiveness of care?*<sup>11</sup>

## SOMATIZATION

The clinical trial of the effect of a care recommendation letter for somatization raised many stimulating questions. Epstein<sup>15</sup> began by summarizing: "What we know is this: Physicians cannot explain the majority of symptoms that patients experience. Most of these symptoms resolve spontaneously. These patients are not malingering. And, all symptoms, regardless of whether they are explained or unexplained, physical or psychological, tend to improve if patients feel understood, reassured, exculpated and trusted by their physician."

What is lacking, still, is an adequate theory of somatization, "... how to provide reassurance to the patient while accepting that there are intrinsic uncertainties that always result from imperfect knowledge?"<sup>15</sup>

*What is the clinician role in fostering somatic fixation?*<sup>16</sup>

*Is the declining effect of the care recommendation letter with time a reflection that patients eventually reject the physician's explanation for their continuing symptoms?*<sup>17</sup>

*What is the effect of the care recommendation letter on physician behavior? When the effect of the letter seems to decline with time, is it the patient or the physician who needs a "booster"? Does the patients' stress, which some theorize is a cause of somatization, manifest in other ways than the behaviors that the letter appears to affect?*<sup>18</sup>

## CONTINUITY OF CARE: JUSTIFIABLE? WHAT ABOUT VERY LONG-TERM CONTINUITY?

Wall<sup>19</sup> had differing responses to the studies of continuity of care featured in the third issue of the *Annals*. Wearing the hat of the health services researcher and clinician, he agrees with Christakis<sup>20</sup> that continuity of care is so important that it must be considered an outcome of care. Wearing the hat of health plan administrator, however, he is "hard pressed to justify continuity of care at the policy level." Building on the study by Nutting et al,<sup>21</sup> he asks us "... to define a research agenda in this area that focuses on those individuals for whom continuity might be especially important. ... In the current period of hospitalists and ambulatory care specialists, where does continuity have a role?"<sup>19</sup>

Saultz,<sup>22</sup> in response to the *Annals* third issue, which included his review article on "Defining and Measuring Interpersonal Continuity of Care,"<sup>23</sup> raises additional questions:

"1. What are the key events that occur early in such a relationship that promote a bonding between doctor and patient? 2. Are long-term doctor patient relationships more likely between doctors and patients who have other long-term relationships in their lives? 3. While doctors and patients may like long-term relationships, do such relationships actually improve care in any measurable way? 4. Would patients who aren't in long-term relationships be more satisfied or get better care if they were put into such a relationship? 5. Can we learn something about long-term relationships by studying how doctor-patient relationships end? Perhaps a long term relationship is one that hasn't had a reason to end!"<sup>22</sup>

Candib,<sup>24</sup> concurring with Bagley<sup>25</sup> and Saultz,<sup>22</sup> notes that we have not investigated the effects of "Very Long Term Continuity."<sup>24</sup>

*"What are the effects of very long term continuity? What happens when continuity not only affects an individual, but a family, including multigenerational families cared for (and perhaps attended at birth and death by) the same doctor?"*

We look forward to your continued thoughtful work in bringing this research alive with your personal experiences, information from the literature and your own work, and other ways of knowing.

## THE BANFF DECLARATION

A very important discussion is taking place in the *Annals* Open Forum. The Banff Declaration<sup>26</sup> recommends that the International Classification of Primary Care (ICPC-2-E) be adopted as the basis for documentation of primary care in the United States. Already in use in much of the rest of the world, and easily linked to other classification systems, ICPC reflects the processes by which people and their illnesses present and progress as they participate in primary care. The implications of adopting ICPC in the United States are profound, and this discussion is very timely in light of the recent HIPAA legislation that requires the National Committee on Vital and Health Statistics to make recommendations on standards for patient medical record information. The editors encourage all readers to read and join in this important discussion and to participate in the actions that are likely to result.

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## CORRECTION

Franks P, Cameron C, Bertakis KD. On being new to an insurance plan: health care use associated with the first years in a health insurance plan. *Ann Fam Med.* 2003;1:156-161.

After publication of this article, additional information was provided by the insurance company that may affect interpretation of some of the study results. Specifically, the method of identifying "those who are new to a health plan" resulted in a substantial number of false-positives. We identified new subscribers by determining whether their unique identification number had appeared in previous years. We have discovered, however, that an individual may also acquire a new unique identification number under the following circumstances: changing to a spouse's coverage, some changes in marital status, change from parent's to self-coverage, and changing to a different health plan with the same insurer. This last change may have occurred during the time period of the study as a new, more restrictive, lower cost plan was being marketed. Although the contribution of each of these situations is unknown, the audited disenrollment rate of the plan, as reported to NCQA during the study time period, averaged 12.0%. This disenrollment rate does not include any of the situations noted above.

Thus, the average disenrollment rate cited in the article of 19.6% overstates the audited rate by about 50%. Some of these false-positives reflect circumstances that probably would not result in changes in health care; others might result in changes in health care as enrollees make adjustments to new situations and new coverage. Even so, the reported effects on utilization (lower mammography rates, greater risk for avoidable hospitalization, and higher costs among "new" enrollees compared with those who have not changed their plan) must reflect effects averaged across both those who are truly new and those who changed their identification number but not their plan (false-positives). The observed differences therefore suggest greater differences among those who are truly new diluted by the effects of those who are not new (but false-positives).

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