Procedures in Family Practice

What’s Best for Your Patients and for You

WHICH DIAGNOSTIC and screening procedures should you personally offer your patients and which should you leave for your consultants? A survey of family physicians in the state of Washington provides information worth considering as we approach major, but, as yet, undefined changes in the US health care system. The survey provides data from only one state and only on those physicians belonging to the Washington Academy of Family Physicians. It was conducted in 1989, well before support for health care reform gathered momentum. The same family physicians might respond differently today and may well respond differently 12 months from now. However, the subject of diagnostic and screening procedures in family practice is a timely one. In the current context of a changing health care environment, the responses of these physicians 4 years ago offer useful insights to those of us considering the addition of new procedures to our practices today.

We all know that the addition of a new procedure to the office is not trivial. It often involves training for ourselves and our office staff, compliance with various regulations, acquisition of capital equipment, and assessment of competency. Initial implementation is not the end of the story, because once the procedure is introduced to the practice, patients need to be educated, bills need to be explained, and skills and equipment need to be maintained.

In 1989, almost all survey respondents conducted the Papanicolaou smear test on their patients and 58% or more carried out electrocardiographic testing and interpretation, endometrial biopsy, pulmonary function testing, and rigid sigmoidoscopy (52%, with some undefined overlap, offered flexible sigmoidoscopy). A national survey of general internists conducted several years earlier identified similar common procedures. In 1993, this basic list of procedures, with minimal modification, still seems appropriate.

In 1989, these Washington physicians were also queried about their plans to offer new procedures. Through our 1993 "retrospectoscope," four of the top six procedures that they mentioned appear to be sound additions to the basic list of procedures and have recently gained new support.

Flexible sigmoidoscopy topped the list of planned new procedures in 1989, with 59% of those not yet offering it intending to. This choice is better supported now. A recent case-control study suggests that rigid sigmoidoscopy reduces mortality from rectal and distal colon cancer, and most practitioners see clear superiority in terms of screening and patient compliance with the flexible scope. In a randomized trial demonstrating a 33% decrease in deaths due to colorectal cancer with annual fecal occult blood testing, colonoscopy was found to be necessary to evaluate positive stool test results in 38% of patients during the 13-year follow-up period. The reduced mortality rate with annual fecal occult blood testing may have been achieved directly, or even surpassed, by screening each patient every 10 years with flexible sigmoidoscopy. At the least, this study suggests that we may be called on to follow-up more and more positive fecal occult blood test results and that the combination of flexible sigmoidoscopy and barium enema examination is a reasonable alternative to colonoscopy.

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Offering pulmonary function testing, smoking cessation groups, and endometrial biopsy also seem even wiser now than in 1989. The National Asthma Education Project supports the role of such office and ambulatory monitoring for asthmatics. The continued need for smoking cessation groups and other therapies, in addition to nicotine patches and gum, is clear. With increased understanding of the benefits of postmenopausal estrogen replacement therapy and the number of women for whom we prescribe it, the need for endometrial biopsies will also increase.

Colposcopy ranked second on the list of procedures that physicians planned to add and cervical biopsy, which is often linked to colposcopy, ranked fourth. While colposcopy has its advocates among family physician educators and is certainly an appropriate skill for family physicians caring for high-risk populations, we are less
enthusiastic about adding it to the basic list of family physician skills in 1993.

How many women in your practice require colposcopy annually? In our practice, it is relatively few. In northern New England, there is no shortage of competent gynecologists who perform the procedure. Few patients would have to travel more than an hour to obtain one, however, we recognize that the travel time in some other places would be much longer.

Health care reformers suggest that family physicians may soon be busier providing the full spectrum of primary care to people who previously received it from procedure-oriented specialists. Furthermore, lucrative reimbursements for procedures may soon be a thing of the past. This is not the time for most practicing family physicians to devote the effort or the capital investment to adding colposcopy to their list of procedures.

Another concern is that the availability of a service seems to increase its use, regardless of whether it is appropriate. Physician self-referral has been much discussed of late. Primary care physicians who own roentgenography units are much more likely to order roentgenograms without clear benefit to the majority of patients than are physicians who refer their patients to a radiologist. In our experience, the great majority of physician self-referrals for roentgenography are appropriate or at least well-intended. We do not quarrel with physicians owning roentgenography units, especially if it is intended to spare ill patients the inconvenience of travel elsewhere to obtain a roentgenogram. Self-referral for colposcopy may be a different story, and a "travel barrier" to obtaining it may not be so bad because current indications for colposcopy are not entirely clear. One family physician expert recently registered concern about the potential for overuse of colposcopy with the introduction of new cervical cytology sampling methods.

The 1989 survey suggested a great enthusiasm for adding procedures. In the current health care environment, we believe that such enthusiasm should be tempered. Although adding procedures such as flexible sigmoidoscopy, which are directed at health screening and prevention, is appropriate now, more effort should be devoted to actually providing already existing services and procedures to more of our patients who need them. The National Cancer Institute Breast Cancer Screening Consortium has indicated that physicians miss many opportunities to recommend screening mammography to patients aged 50 years and older. Most physicians overestimate the proportion of their patients to whom they provide appropriate smoking cessation counseling, mammography, Papanicolaou smear tests, and clinical breast examination. Some patients with abnormal screening results are not followed up in a timely manner. We suggest that before adding new screening or diagnostic procedures, family physicians should make sure that they are providing currently available screening procedures appropriate to all patients who need them. Investing a few hours of office staff time to audit current screening services before investing many hours and dollars in a new procedure is justified.

The Washington survey offers a valuable service, but some limitations should be recognized. In addition to being 4 years old, it is based on physician self-report, and not on direct observations, of the frequency or level of competence at which services are provided. Procedures that are outside the domain of diagnosis and screening of cancer and cardiovascular disease are not addressed. No information is provided about contraceptive and family planning procedures, such as vasectomy, for which ready access and the context of an established physician-patient relationship may offer great value.

Reflection on the survey suggests several questions to be considered before deciding to add new procedures to a practice:

- Will the procedure be required frequently enough to justify the training time and capital expenses?
- Will the procedure be required frequently enough to justify maintenance of your competency and your staff's efficiency?
- Will patient access or continuity of care have bearing on whether you offer the procedure? How difficult is it to obtain the service elsewhere? Is the nature of the procedure such that providing it in the context of continuity of care important?
- Can you offer the procedure at a similar or lower cost than your consultant?
- Is reimbursement for the new procedure unlikely to be affected by health care reform?
- Finally, can you ensure not to overutilize the new procedure?

In summary, the immediate future should be a time of caution in adding new procedures to your practice. Adding some procedures is clearly justified if they are not currently being offered. Adding some others is less prudent, especially if they require a major investment in time, energy, or money. The next year may well bring changes in US health care that are of the magnitude of the establishment of Medicare in the 1960s. If you can answer "Yes" to all our questions, it may be reasonable to add the new procedure that you are considering. If not, it may be better to wait than to bet on an uncertain future.

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- In Table 2, on page 490, in the row labeled “All causes” and the column labeled “All Series,” the numbers in parentheses should be “0.042-0.052.” In the same row, under the column labeled “Radical Surgery,” the number outside the parentheses should be “0.032.” In the same row, under the column labeled “Radiation Therapy,” the number outside the parentheses should be “0.045.”

- Also, in Table 2, in the row labeled “Cancer-specific causes,” and the column labeled “Radical Surgery,” the “n” should be “23.” In the row labeled “Median annual rate of distant metastasis,” and the column labeled “All Series,” the “n” should be “50.”

- In the text on page 490, under the heading “Surgical Removal of Cancerous Tissue,” the rate of disease progression within 5 years of diagnosis should be 3% (not 1%) for the report by Morton et al. On page 493, reference 15 should be reference 16, reference 16 should be reference 17, and reference 17 should be reference 15.