The System Is Cruel

The Editorial by Broadhead1 in the April 1994 issue of the ARCHIVES is indeed absolutely correct and timely. My objection is to his final conclusions of being honest and truthful in coding. I am still active after 45 years in family medicine. The bottom line by any good family physician is “do no harm.” The two most frightening words to all of us are cancer and psychiatric. Say what you want—this is a human trait. Perhaps centuries down the road humankind will be different.

This past year I spent 45 minutes with a delightful woman who has been a patient of mine for at least 30 years and who had several situational problems. I coded the problems with a psychotherapy number. When she received the Medicare copy of her visit, the listing of a psychiatric diagnosis and treatment was devastating to an already hurting person.

The system is cruel.

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GAPS in Family Planning Care

I read with great interest the article by Dietrich et al1 in the February issue of the ARCHIVES on the preventive GAPS (goal setting, assessment, planning, and start-up) approach to improving preventive care in office practice. We at the Presbyterian Hospital System in Albuquerque, NM, have identified one area—family planning and the prevention of unintended pregnancy—that merits a systematic approach to prevention, and the GAPS approach may be a useful tool for us. I am writing to thank the authors for describing this approach, but also to encourage them and others to consider the prevention of unintended pregnancy as an additional goal that may be of value in improving health2 and lowering health care costs.

The goal of reducing rates of unintended pregnancy has been supported by several national groups3 and task forces4 and is a worthwhile area for improvement. Improvement in this area is also key to any attempts to deal with welfare reform. Although most political initiatives to reduce the size and cost of welfare programs focus on getting people off welfare sooner, a much better approach would focus on helping people avoid getting on welfare in the first place. Aside from the elderly in long-term care, the biggest welfare program is Aid to Families with Dependent Children (AFDC). The main entry point to AFDC is childbirth, and the evidence is clear that most births to AFDC recipients are mistimed (the pregnancy occurred before it was wanted or planned) or unwanted (the pregnancy was not wanted then or ever in the future). For example, in Oklahoma in 1991, only 37% of AFDC births were intended pregnancies, whereas 43% were mistimed and 20% were unwanted ever.6 A recent article (Washington Post Weekly Edition. January 17–23, 1994;24) pointed out that “welfare benefits probably have far less impact on illegitimacy than does poor women’s lack of access to contraception and abortion.” This is not just a political and economic issue; it is an issue for health care, and any solution will require improvement in health care systems, including office practice.

In a study done in my office of 100 consecutive patients who requested termination of pregnancy, I found that the medical care system had failed for 30%. These patients included (1) patients who had no risk factors associated with the use of a more effective contraceptive method and who had contact with the medical system but were not prescribed a more effective method; (2) patients who were advised to discontinue an effective method (oral contraceptives) because of minor problems amenable to management by a change of pill formulation or counseling; and (3) patients who quit using oral contraceptives on their own and who had contact with the medical system but for whom the risk of an unwanted pregnancy was not assessed. Compared with the 30% for whom the medical system neglected, the birth control method failed in 17% and 27% neglected to use the contraceptive method chosen.

We must do better, and we must have tools such as the GAPS approach to assess the opportunities for improvement.

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