PRIMARY CARE

for the OBSTETRICIAN and GYNECOLOGIST

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To
Capt. Marco Labudovich, MC, USN (deceased)
Your leadership, scholarship, and unwavering dedication
to women's health care influenced a generation
of young physicians at Portsmouth Naval Hospital.
Your untimely death never allowed you to savor
the fruits of your labor.
Thanks from all your students.

▸ Preface

Primary care is not a specific type of care—it is an approach to the patient and her needs, both in wellness and disease.

The goal of primary care is to treat the total patient, to maintain her health, to counsel her about risks, to prevent disease when possible, and, when disease occurs, to detect it in early stages and ensure that the care needed is provided. To be a good primary care physician is to be a good physician in the most traditional sense.

Because of changes in today's health care environment, the issue of who provides primary care has become germane. Increasingly, expensive technology has become burdensome for many patients who, perhaps naively, wish to receive more primary and preventive care. Insurance companies and third-party reimbursers are concerned that rising costs are caused by increased use of technology and diagnostic testing, although this observation has not been adequately studied or verified. As a measure of controlling costs, large health care corporations have instituted systems requiring all care to be channeled through primary care physicians. As an outgrowth of these initiatives and concerns, more physicians have been enticed to enter primary care fields—and to claim rights to the newly esteemed primary care designation.

During the health care battles of 1993 and 1994, the

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American College of Obstetricians and Gynecologist became concerned that primary care issues had not been adequately addressed both in residency and in continuing medical education within the specialty. As a result, the components of primary and preventive care were identified as means of guiding further educational efforts. Even though obstetricians and gynecologist do an excellent job of caring for patients between 15 and 44 years of age, many areas have been overlooked. These deficiencies fall into areas of basic medical skills as well as in providing care for common medical conditions that are outside reproductive biology. Obstetrician–gynecologists are in a unique position to provide a full spectrum of care to patients because of the traditional focus of the specialty on routine and preventive care and the trust they have engendered in their patients on an ongoing basis. The obstetrician–gynecologist needs to become a "gate keeper" to eliminate "lock out" in the care of women. To realize this goal, an expansion of ongoing education is necessary in residency and in the "reeducation" of the practicing physician. In many areas of the country, these issues are being actively addressed and implemented.

The goal of this book is not to replace a general internal medicine textbook. It is merely meant to be a framework and quick reference for evaluation and therapies of some of the more frequent primary care problems that occur in office practice. It is not the intent of this textbook to be global, but rather to focus on key areas that can guide physicians in early detection and manage-

ment of prevalent conditions that have an impact on women's health. This approach is also reflected in algorithms, which are used liberally to show a step-by-step plan for diagnosis and management. All dosages of medications are presented as currently available. However, medicine changes very quickly and readers are encouraged to confirm dosages as well as to keep abreast of emerging issues.

It is my express commitment to women's health care in obstetrics and gynecology that we offer the type of care that is both sensitive and caring as well as preventive. It is hoped that this textbook will reflect these goals and allow the obstetrician–gynecologist to continue to be the primary advocate for women.

I would like to thank Louise C. Page, editor from Wiley, for hounding (and encouraging) me to tackle this impossible project; CDR Richard Hawkins, MC, USN, a loyal internal medicine colleague who helped me through residency and agreed to proof the manuscript of this book for accuracy; and Rebecca Rinehart, whose contribution to the education of obstetricians and gynecologists through her editing has probably been underappreciated by the rank and file of ACOG.

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▶ SECTION 1

THE BASICS OF PRIMARY CARE

The first two chapters establish the groundwork for primary care and the foundation on which it rests—the principles of primary and preventive care and screening. Chapter 1 is devoted to the evolution of primary care, describing economic and scientific factors that contributed to today's health care environment and why primary care has become an issue. Chapter 2 is a difficult and, in many practitioner's opinion, boring aspect of medicine: the principles of screening tests. An attempt has been made to present the concepts using real-life examples instead of mathematical models. As health networks expand and analyses of emerging information become available, screening issues will be determined not by specialty societies but by outcome data. Therefore, these issues may drive medicine, especially preventive and public health efforts, for the next decade.

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► CHAPTER 1

The Evolution of Primary Care

Western minds are trained to "do something"—to intervene rather than to reflect. "The chance to cut is the chance to cure." This mentality is common in most physicians' psyches, especially when a specialty becomes procedure driven. The laudable goal of medicine is to eliminate disease and suffering and, paradoxically, to eliminate itself. The hardest lesson for most physicians, which some never learn, is how and when to use technology and testing. This becomes obvious in comparisons of young physicians with their older colleagues when faced with a dying patient. The philosophy of "doing everything I could" takes the physician off the emotional hook and has been a driving force in medicine in the United States. Unfortunately, when closely scrutinized, many therapies and interventions help physicians to absolve themselves of guilt rather than help patients. The interventional nature of modern medicine has supplanted preventive health care, which although often applauded is usually poorly funded. Additionally, to see the results of preventive health care in a population constantly on the move and requiring decades of study is neither satisfying nor tangible for either the physician or the patient.

For many years, health care was driven by physician's fees, which were, in most cases, arbitrarily determined. The degree of training, technical difficulty of procedures, popularity of a practice, and what the market would bear (or what insurers would reimburse) were important variables in determining compensation. The three A's of private practice—amiability, availability, and ability, in that order—continued to be major driving forces. There were no standards for outcome assessment: the surgeon who operated on low-risk patients, performing low-risk procedures, would be assumed to be a "better" surgeon in superficial comparisons. Cost control was more an issue of overhead than the type of care offered. Obstetricians and gynecologists were able to effectively market their services as the experts in the field of women's reproductive health with little resistance from other specialties. Market forces of supply and demand were of less importance than perceived "quality" of care. Many of these issues have been important for decades, especially considering that the cost of health care as a function of gross domestic product was less than 10% and not perceived as a national problem.

The 1980s were marked by an explosion of technology in testing, imaging, and surgical procedures and a corresponding explosion of profits. The cost of this care became exorbitant and, rather than consolidating technology, each center competed (and with antitrust laws in force, was forced into competition) to be the first hospital to offer services. The academic medical centers, driven by researchers whose promotion and tenure were tied to harnessing these technologies, trained more individuals to perform procedures and therapies. The extraordinary heart–lung transplant became mundane, performed in multiple medical centers at prohibitive costs. Who can deny any citizen the right to these procedures? Americans desire

top-of-the-line care for every individual, regardless of their ability to pay, and at low prices. Hence the entitlement mentality of the consumer has fueled this explosion.

Despite the desire "that everything be done," little information on standardization of outcomes is available for analysis to determine who would benefit from a proposed test or procedure. The physician, buffeted by the wants and needs of the patient and trained to be an advocate regardless of ability to pay, was made responsible for cost containment. Needless to say, physicians are poorly trained to manage their own finances, let alone health care costs. Insurance companies became more interested in care provided for specific indications. This involvement has led to the creation of a bureaucracy that in most analyses has added to cost rather than contained it. The additional burden of an atmosphere heavy with litigation, in which every decision is scrutinized by attorneys whose goal is recovery and not scientific validity, has added to the need for "objective evidence" (read tests and procedures). Where is the physician to turn?

Despite the gloom and doom atmosphere prevalent in medicine today, some rays of hope are present. Money spent for elaborate technology will be consolidated within large corporations, which are buying both hospitals as well as health care provider resources. The science of testing and screening will no longer be in the domain of the academic medical center, influenced by the inherent bias of the populations served, but will be generated by outcome analysis. This methodology removes the physician from offering certain services. The modern obstetrician–gynecologist will have to learn how to effectively gather data on outcomes and prove that care rendered is appropriate and beneficial. In many ways, this approach could allow the physician to become free of some tech-

nology that has been advocated by national organizations and to focus on issues germane to patient care.

Technology may be helpful in delivering health care in new and unique ways. Medical recordkeeping and retrieval are archaic at best. Every new patient seeking care from a provider comes with little information relating to prior services rendered, ongoing problems, medications, and family history. Added to the confusion is the manner in which the information is presented to the provider. One needs only to request narrative summaries and operative reports to reveal how little many very intelligent patients understood of the care they received. Valuable time is wasted collecting redundant data rather than "connecting" with the patient on such relevant issues as work, family, and the inherent stresses of life. If properly designed, the use of standardized forms and computer databases will allow a patient and her physician quick access to medical records. They may also signal when an immunization is indicated and when preventive testing should be initiated.

What do all these issues have to do with primary care? Patients (not clients!) prefer to have a single provider with whom they work well and feel comfortable. Traditionally, obstetrician–gynecologists have been women's health care advocates and most women would prefer receiving care from physicians in the specialty. Unfortunately, as medical education has changed, so too has the specialty, which in many ways has narrowed. Economic and political forces are *demanding* primary care physicians become decision makers and, consequently, are steering patients toward the cheapest and most effective provider. For obstetrics and gynecology to survive as a specialty in the current scope of care, it must change from a procedure-based specialty and become more focused on total patient care. Total patient care requires that physicians, who

may be uncomfortable caring for some common diseases, expand the care they offer. Once the patient leaves the practice, the provider may never see that patient again. Unfortunately, other specialties have not been active in women's health care. For obstetricians and gynecologists to continue to remain competitive, we will need to return to basic "doctoring" skills and the care of common diseases. We are capable of assuming this role and have a tradition of doing so. This book provides the preparation for a basic approach to primary care and it is hoped will help relieve some of the anxiety associated with change.

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