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Missed Opportunities for Coronary Heart Disease Diagnoses: Primary Care Experience – Whose Experience Is It?

Turkay M, Senol Y, Alimoglu MK, Aktekin MR, Deger N. Missed opportunities for coronary heart disease diagnoses: primary care experience. *Croat Med J.* 2007;48:362-70. [Medline:17589980](https://doi.org/10.3325/cmj.2007.48.362)

To the Editor: I have read the article by Turkay et al (1) with great interest. The authors studied the missed opportunities for detection of coronary heart disease and related risk factors in primary care. The number of missed diagnoses shows that there is something missing. So, why have they missed them and what was missed?

The authors hypothesized that there would be some undiagnosed coronary heart diseases in a primary care center and they found that was the case. It seems that the authors conducted this study from an outsider's perspective, not giving any clue as to what kind of interaction they had with the physicians before, during, and/or after the data was collected. Primary care center was a medium, an alternative to doing a prevalence study.

As mentioned in this study, referral system in Turkey does not work properly for various reasons. Patients may choose the primary, secondary, or tertiary care. Gate-keeping mechanism does not work (2). How do we know that opportunities for ear-

ly detection of diseases have not been missed in the secondary or tertiary care?

Continuity of care is an essential component of primary care and family practice. The family doctor develops a feeling of "responsibility" for the particular patient if there is an enduring relationship between her or him and the patient. Keeping health records also provides the continuity of care. Without good records it is not easy to estimate which patients have never been diagnosed with cardiovascular disease (3).

The authors explained this with the workload of the primary care physicians, their relations with the secondary and tertiary care, and lack of training. Although all this makes sense, there have been not enough evidence from studies including primary care physicians' performance and patient's demand and health attitude in general or in situations similar to that described by the author. Since the management of chronic diseases is a problem all over the world, patients also share the responsibility.

Risk assessment in primary care needs a systematic approach, which may take longer than dealing with a complaint or symptom. Physician's workload may be a barrier to it. However, health enhancement, risk

avoidance, and risk reduction are more important steps than early detection (3). Programs for health promotion through public policies are the key for management of cardiovascular risk factors. The World Health Organization points out this is a long-term goal, which needs national, integrated community-based programs to prevent cardiovascular diseases and other major non-communicable diseases (4). Public health professionals are the right people to propose such programs to the government.

Under- and postgraduate education for primary care/family medicine seems to be another key point here. Undergraduate education is mainly performed in the tertiary care, however only 5-10% specialize, while the rest start to work in primary care settings. Even though attempts to introduce family practice as a specialty are not new, a country-wide implementation has not been possible for the last two decades. Training in family practice is provided in major training hospitals (5), and the emphasis placed on a community-based training is fairly new. New efforts to overcome these obstacles have been addressed by introducing short-term courses (6) or continuing medical education courses. Nevertheless,

this will not replace a well structured residency program in family practice (7).

The article touches a sensitive issue for the Turkish health services. A constructive move with an objective look seems necessary. Further studies in the primary care setting might be the key point and may construct a partnership between the secondary/tertiary care and primary care physicians.

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In reply: I would like to thank Dr Banu Ulusel for her

useful comments, which I have read with great interest. First, let me clarify our study design. We hypothesized that there would be some undiagnosed coronary heart disease cases in a primary care center and we found that this was the case. There was no interaction between researchers and primary care physicians, as we performed our study in the waiting room of the primary care centers, as the patients were moving in and out of the examination room. Without mentioning the aim of our study, we just asked the primary care physicians to send us 1 of each 3 patients they had seen (1). However, after a while, they started to use the researchers as consultants for some hard-to-diagnose patients. Since such an interaction would compromise the aim of the study, we had to stop.

As we mentioned in our article, referral system in Turkey does not work properly for various reasons. It is widely known that patients may apply to the primary, secondary, or tertiary care without any barrier and gate-keeping mechanism (2). The Ministry of Health currently gives no effort to change this situation (3). Our results are applicable only to primary care settings and to patients who use primary care. Although it is highly possible that opportunities for early detection of some serious diseases are missed on the secondary and tertiary level,

due to the lack of a holistic approach to patients, we cannot reach such a conclusion solely on the basis of our results. The intention of our study was not to blame primary care physicians for missing opportunities. We just recommend primary care physicians to adopt a bio-psycho-social approach and keep some common serious diseases, such as breast cancer, cervix cancer, or hypertension in their minds as a part of their differential diagnostic procedure. This approach provides cost-effectiveness as well as an improvement in medical outcomes.

We totally agree with Dr Ulusel that, without studies including primary care physicians' performance and patient's demand and health attitude, it is hard to explain "missed opportunities" with a physician workload, ie, daily patient numbers in primary care settings.

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