

Letters to the Editor



The journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Measures of Quality of Care

To the Editor:

I wish to congratulate you on the publication of Dr. Jack Froom's article (*Froom J: Assessment of quality of care by profiles of physicians' morbidity data. J Fam Pract 3:301-303, 1976*).

It is important that increasing emphasis on evaluation take place. I would, however, like to point out some objections I have to the methodology described which could lead to erroneous assessment of a physician's diagnostic acumen.

I do not believe outcome is difficult to measure. It depends on what is being measured. Dr. Froom discusses three points: structure (data base, organization), process, and outcome. Process is basically a measure of efficiency. Inefficiency leads to ineffective outcomes. Process, however, is of little value unless you know whether the expected outcome is, in effect, achieved. It is putting the cart before the horse. Diagnoses are enabling objectives. They are the "outcome" of patient assessment, and determine treatment to be provided. They are stepping stones to final outcome (prevention of disease onset, reduction of morbidity, elimination of disease, delay of death). There are additional measurements such as reduced pain and discomfort, reduced work loss, reduced time spent in bed, reduced costs, etc.

In discussing the distribution of diseases in a physician's practice, Dr. Froom missed an important epidemiological and statistical association. The denominator for disease rates has to be

the community population from which the practice population is drawn. The effectiveness of diagnosis cannot be made unless we know the probability that presence of disease is correctly diagnosed (sensitivity) and absence noted (specificity). Comparability from one physician to another is of little value by itself.

A physician's patient population is usually a biased sample of the community, except in a closed population, which selects from certain population groups depending on the physician's interests. Prevalence of disease is affected by age, sex, race, economic level, geography, and education as a minimum. Allowing voluntary participation of physicians inevitably means the patient population will be biased, because some physicians and agencies will not take part in the survey.

Careful national population surveys have been made based on above factors to look at chronic diseases, such as hypertension, diabetes, obesity, coronary disease, emphysema, and osteoarthritis to mention a few. We can calculate the expected prevalence of disease in a practice when we know the appropriate information about the patients. If, for instance, local community estimates of disease prevalence show 15 percent hypertension, 2.5 percent diabetes, 20 percent obesity, 5 percent alcoholism, and 6.5 percent fertility, we can adjust the patient profile to match the community profile and look for similar prevalence of diagnoses among the physician's patients. This will allow

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IN ACUTE OTITIS MEDIA WHILE AN ANTIBIOTIC ATTACKS THE PATHOGEN



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BRIEF SUMMARY

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(contains not more than 0.6% moisture)
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measurements of sensitivity and specificity of diagnostic ability, as well as validity (calling an apple an apple), comparability (making sure one physician's diagnosis is based on the same data as another's) and reliability (probability of calling an apple an apple each time you see it).

To ensure appropriate peer review, it is necessary that measures be chosen which can act as appropriate markers of performance. The chronic diseases, because of their longevity and because they are more appropriate than the acute diseases where prevalence is usually unknown and diagnostic reliability is poor, should be the diseases chosen for peer review initially.

I would, therefore, suggest that Dr. Froom's model be improved by use of appropriate epidemiologic and statistical techniques to make peer review a meaningful exercise.

*C.M.G. Buttery, MD, MPH
Eastern Virginia Medical School
Norfolk, Virginia*

The above letter was referred to Dr. Jack Froom who responds as follows:

I am grateful to Dr. Buttery for his careful review of my article. I do not agree that outcomes are easily measured. The natural history of health problems for diseases encountered in the ambulatory setting is not known with sufficient precision to make evaluations of medical interventions and their consequent effect on outcomes a simple matter. For example, we do not yet know with certainty the benefits of routine examination of healthy patients,¹⁻⁴ the use of antibiotics for such common conditions as epididymitis⁵ and otitis media,⁶ and the use of oral hypoglycemic agents for the treatment of diabetes mellitus.⁷ It is, therefore, difficult for the clinician to prove that he has

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Brief Summary

INDICATIONS

PLACIDYL is indicated as short-term hypnotic therapy in the management of insomnia.

CONTRAINDICATIONS

PLACIDYL is contraindicated in patients with known hypersensitivity to the drug and in patients with porphyria.

WARNINGS

PLACIDYL SHOULD BE ADMINISTERED WITH CAUTION TO MENTALLY DEPRESSED PATIENTS WITH OR WITHOUT SUICIDAL TENDENCIES; IT SHOULD ALSO BE ADMINISTERED WITH CAUTION TO THOSE WHO HAVE A PSYCHOLOGICAL POTENTIAL FOR DRUG DEPENDENCE. THE LEAST AMOUNT OF DRUG THAT IS FEASIBLE SHOULD BE PRESCRIBED FOR THESE PATIENTS.

Patients should be advised that, for the duration of the effect of PLACIDYL, mental and/or physical abilities required for the performance of potentially hazardous tasks such as the operation of dangerous machinery including motor vehicles, may be impaired.

Usage During Pregnancy and Lactation: PLACIDYL is not recommended for use during the first and second trimesters of pregnancy. Also, clinical experience has indicated that PLACIDYL when taken during the third trimester of pregnancy may produce CNS depression and transient withdrawal symptoms in the newborn.

Reproductive toxicity testing of PLACIDYL was carried out in rats. A somewhat higher percentage of stillbirths and a lower survival rate of progeny was observed among animals given 40 mg./kg./day.

The safety of use of PLACIDYL during lactation has not been established.

Drug Interactions: Patients should be cautioned that the concomitant use of PLACIDYL with alcohol, barbiturates, other CNS depressants, or MAO inhibitors may produce exaggerated depressant effects.

Ethchlorvynol may cause a decreased prothrombin time response to coumarin anticoagulants; therefore, the dosage of these drugs may require adjustment when therapy with ethchlorvynol is initiated and after it is discontinued.

Transient delirium has been reported with the concomitant use of PLACIDYL and amitriptyline; therefore, PLACIDYL should be administered with caution to patients receiving tricyclic antidepressants.

Usage in Children: PLACIDYL is not recommended for use in children since its safety and effectiveness in the pediatric age group has not been established.

Psychological and Physical Dependence: PROLONGED USE OF PLACIDYL MAY RESULT IN TOLERANCE AND PSYCHOLOGICAL AND PHYSICAL DEPENDENCE. PROLONGED ADMINISTRATION OF THE DRUG IS NOT RECOMMENDED.

Signs and symptoms of intoxication have been reported with the prolonged use of doses as low as 1 Gm./day. Signs and symptoms of chronic intoxication may include incoordination, tremors, ataxia, confusion, slurred speech, hyperreflexia, diplopia, and generalized muscle weakness. Toxic amblyopia, scotoma, nystagmus, and peripheral neuropathy have also been reported with prolonged use of ethchlorvynol; these symptoms are usually reversible.

Pulmonary edema of rapid onset has resulted from the I.V. abuse of PLACIDYL (ethchlorvynol).

Severe withdrawal symptoms similar to those seen during barbiturate and alcohol withdrawal have been reported following abrupt discontinuance of prolonged use of PLACIDYL. These symptoms may appear as late as nine days after sudden withdrawal of the drug. Signs and symptoms of PLACIDYL withdrawal may include convulsions, delirium, schizoid reaction, perceptual distortions, memory loss, ataxia, insomnia, slurring of speech, unusual anxiety, irritability, agitation, and tremors. Other signs and symptoms may include anorexia, nausea, vomiting, weakness, dizziness, sweating, muscle twitching, and weight loss.

Management of a patient who manifests withdrawal symptoms from PLACIDYL involves readministration of the drug to approximately the same level of chronic intoxication which existed before the abrupt discontinuance. (Phenobarbital may be substituted for PLACIDYL.) A gradual, stepwise reduction of dosage may then be made over a period of days or weeks. A phenothiazine compound may be used in addition to this regimen for those patients who exhibit psychotic symptoms during the withdrawal period. The patient undergoing withdrawal from PLACIDYL must be hospitalized or closely observed, and given general supportive care as indicated.

PRECAUTIONS

Elderly or debilitated patients should receive the smallest effective amount of PLACIDYL (ethchlorvynol).

Caution should be exercised when treating patients with impaired hepatic or renal function.

Patients who exhibit unpredictable behavior, or paradoxical restlessness or excitement in response to barbiturates or alcohol may react in this manner to PLACIDYL.

PLACIDYL should not be used for the management of insomnia in the presence of pain unless insomnia persists after pain is controlled with analgesics.

ADVERSE REACTIONS

Nausea, vomiting, gastric upset, aftertaste, dizziness, blurred vision, facial numbness, and hypotension have occurred.

Hypersensitivity reactions have included skin rash, urticaria, and occasionally, thrombocytopenia and cholestatic jaundice.

Mild "hangover" has occurred.

The following idiosyncratic responses have been reported occasionally: mild stimulation, marked excitement, hysteria; prolonged hypnosis, profound muscular weakness, syncope without marked hypotension.

Transient giddiness and ataxia have occurred in patients in whom absorption of the drug is especially rapid, these effects can sometimes be controlled by giving PLACIDYL with food.

(See Psychological and Physical Dependence for the signs and symptoms of chronic intoxication.)

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contributed to "prevention of disease onset, reduction of morbidity, elimination of disease or delay of death" with one of the therapeutic modalities available to him. I do agree that outcome measures are the most desirable measure of quality of care, but such measures have not been shown to be practical in a real health-care delivery setting.

Dr. Buttery proposes the use of disease rates in the community population as a basis for comparison with those rates seen by the practicing physician. Such an approach is unwise for several reasons. The first is that accurate information about the prevalence of diseases in the community is not available. The primary source of this information has been the National Health Interview Survey.⁸ Two studies which compared these interview responses with data derived from physicians' medical records suggest that the survey information from interview does not conform even moderately well with diseases inferred from physician reporting.^{9,10} Secondly, even if such information were available, it is unsound to compare morbidity rates in physicians' patient populations with those of the community because the community contains both patients who seek medical care and those who do not. The prevalence rates may be different in these two populations and comparisons would, therefore, be meaningless. It is, however, rational to compare one physician's morbidity rates with those of his peers. Appropriate adjustments are made for differences in population structure.

I agree that a physician's patient population may represent a biased sample of the community, although the bias is likely to be less for family physicians (who do not limit access according to patient's age, sex, or disease) than for other specialists. For the purposes of our project, the important differences are not those which exist between the patient population and the community, but rather those between the several physicians' individual patient populations. Adjustments of diagnostic profiles are made for the age and sex differences in the individual population against the total patient population of all the peer physicians. The bias introduced by

examining morbidity profiles of only volunteer physicians is likely to minimize differences in physician behavior. Our experience is that there are sufficient differences to make analysis worthwhile.

It is necessary to recognize that common diseases occur commonly. Comparison of the several sources of morbidity data in family medicine such as the National Ambulatory Medical Care Survey, the Medical College of Virginia Data, and data from our own program, reveals far more similarities in morbidity profiles than differences. The differences in rates of diagnoses of these common conditions appear to be physician differences rather than differences in morbidity among the several practice populations. Some reasons for these differences could be a decreased (or increased) sensitivity on the part of the physician, insufficient knowledge of diagnostic criteria, or inadequate data analysis or collection. An analysis of these differences and the provision of appropriate educational material to the physician when indicated cannot help but contribute to better patient care.

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Coding Systems in Family Practice

To the Editor:

I would like to respond to the letter by Dr. Alan J. Bruckheim in the June issue of *The Journal of Family Practice*. He raised several issues which have been concerning many of us involved or interested in the classification and coding of patient problems routinely presented to family physicians.

There seems to be a measure of agreement, at least within the educational hierarchy of the discipline, that there is a need for a coded classification of problems oriented to the needs of family medicine. Some of us feel that the International Classification of Health Problems in Primary Care (ICHPPC) promulgated by the World Organization of National Colleges and Academies of General Practitioners/Family Physicians (WONCA) and published by the American Hospital Association (AHA), represents the best available resource in this area. Time will show whether there is universal agreement as to the appropriateness of this classification, but in the meantime, to avoid losing access to the data already collected by other classifications such as RCGP(US), HICDA, and Canuck, it is necessary to develop transfer codes between ICHPPC and these classifications.

To date, a considerable amount of effort has been put into the development of such a transfer code between ICHPPC and RCGP(US). Representatives of the Department of Family Practice of the Medical University of South Carolina, the Family Medicine Program of the University of Rochester, the Family Practice Residency Program of Lancaster General Hospital, and the Department of Family Practice of the Medical College of Virginia have now reached agreement on such a transfer code. These programs have undertaken to use this transfer code on their own data banks and will make it available to any program which wishes to use it.

To avoid the complications inherent in dealing with such requests on an individual basis, the writer, acting

on behalf of this working group, will be seeking an opportunity to publish this transfer code in a future issue of *The Journal of Family Practice*. Meanwhile, I would like to thank Dr. Bruckheim for his kind remarks and for raising the issue in this column.

Maurice Wood, MD
Medical College of Virginia
Richmond, Virginia

Depersonalization in Medicine

To the Editor:

It would be easy to react to your editorial, "On Depersonalization in Medicine" (*J Fam Pract* 3:239, 1976) by asking, "So what else is new?" Concern for the loss of human values in medicine goes back at least to Sir William Osler and undoubtedly still farther. And yet the problem persists, perhaps because there are so many forces pulling in the other direction. It would be appropriate to look at some of these forces in the hope that identifying them will make them easier to combat:

1. The medical college admissions process tends to select students of high intellectual ability with little reference to their emotional makeup or capacity for empathy. This stems partly from the inadequacy of our tools for measuring personal qualities and partly from widespread resistance to using them to select medical students. Given the present limits of our ability to measure psychological factors, especially in the medical school application context, this reluctance may be well founded.

2. Until recently there has been woefully inadequate emphasis in medical education upon insuring that the young physician understands and is comfortable with his own feelings. It is a truism that one must be comfortable with oneself before one can deal adequately with the feelings of others.

Family medicine has had much to say in this area, and all of medical education has benefited as a result.

3. Another sort of selection process is operative at the time of completion of medical education, with those students of highest intellectual attainment being encouraged to stay in the academic setting. This tends to perpetuate the overemphasis on intellectual characteristics in medical education centers.

4. People naturally tend to concern themselves with the problems that appear most urgent to them, and matters of interpersonal relationships often seem less pressing to the physician than the urgent threats to life or bodily integrity that make up a major part of medical practice.

5. Given the realities of physician-patient relationships, patients seldom confront doctors directly with requests for sympathy or understanding. Such requests are likely to be masked as physical symptoms or hidden behind a veneer of indifference or hostility. The practitioner unskilled in interpersonal relationships is likely to be totally unaware of the messages his patients are trying to convey.

6. Educators tend to measure that which is measurable, and it is virtually impossible to assign meaningful numbers to characteristics such as compassion or facility in interpersonal relations. In this regard I am reminded of the old story of the man who was seen one night scanning the ground beneath a streetlight. A passerby asked what he was doing and he replied that he was looking for his house key. When he admitted that he wasn't sure where the key had been lost, he was asked why he was searching in this particular location. He responded, "Because here I can look."

Clearly, we must continue seeking better ways to communicate with our patients even if this means searching in areas where there is little or no illumination. Nevertheless, the danger of depersonalization in medical care will be with us for the foreseeable future. Essays on this subject must continue to be published at regular intervals to keep us aware of the need to stress the human side of patient care.

Robert D. Gillette, MD
Riverside Family Practice Center
Toledo, Ohio

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