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.

On Changing Medical Practice

To the Editor:

G. Gayle Stephens' articles *(Reform in the United States: Its impact on medicine and education for family practice. J Fam Pract 3:507, 1976;* and *On the teaching and learning of clinical wisdom. J Fam Pract 4:483, 1977)*, I found to be enjoyable and stimulating reading. Dr. Stephens has my admiration for undertaking commentary on these sweeping and important issues. Especially in these times, physicians need his kind of broad philosophical guidance.

Since I am an osteopathic physician, you might expect that I would have a few bones to pick (please forgive this pun) over parts of the article. I appreciated the apolitical tone of the reform article. However, my minority status makes me particularly sensitive to references to "quacks and nostrums." (page 508, column 1). The pejorative reference to "doctors of the people such as homeopaths, naturopaths, and eclectics, who roamed the land at will" betrays an ethnocentricity in an author of otherwise broad perspectives. Those who practice under the aegis of heterodoxy are not necessarily quacks, just as those who identify themselves with orthodoxy are not necessarily scientific physicians. The decline of quacks and nostrums was by no means assured by the discoveries of Pasteur and Koch. The historical fact that the microbiological theories of disease were more enthusiastically embraced by American physicians than by their more conservative European counterparts attests to the peculiarities of the American character more than to the scientific commitment of the physicians who embraced these concepts. Not all of Pasteur's critics were misguided reactionaries. A holistic view of medicine was beginning to form in the minds of many physicians in the 19th century. Some of the medical philosophers of the 19th century foresaw that the germ theory, in spite of its scientific acceptability, would, in its simplistic and popularized version, retard the development of holistic medicine significantly. Looking back over the 20th century, can we not see that their fears were essentially realized? To a physician of my biases and persuasion, the germ theory of disease is still an open question, and by no means a sufficient explanation for most of the health problems which confront my patients. Herbert Ratner, MD, in a paper published by the Center for the Study of Democratic Institutions (1962), commented lucidly on the impact of the American character on the health-care delivery systems which it spawned. George W. Northup, DO, makes a good case for heterodoxy in

Continued on page 732

Continued from page 730

American medicine in his book, *Osteopathic Medicine: An American Reformation* (American Osteopathic Association, Chicago, 1966).

The influence of consumerism on the practice of medicine is properly noted. But the consumer is inappropriately chastised for failing to make a decision regarding his own responsibility for his health. Up until recently, physicians have stood fast on the principle that patients have no business tinkering with their own health. What Dr. Stephens nostalgically refers to as the "current indeterminant nature of the relationship between doctor and patient" hits the nail squarely on the thumb. In these days of transactional analysis, more and more physicians are becoming comfortable with the adult/adult model of the patient-physician relationship as an alternative to the child/adult model which was the standard of the existing system. *(Szasz TS, Hollender MH: A Contribution to the Philosophy of Medicine. Arch Intern Med, 97:585, 1956).*

My urge to correspond with a journal editor became uncontrollable when I read Dr. Stephens' article on clinical wisdom *(J Fam Pract 4:483, 1977).* The problem of interrater reliability has been a matter of great concern to those of us who are involved in teaching physical diagnosis and osteopathic manipulative technique. Antly and Antly to the contrary, I do not believe that physical diagnostic skills are in immediate danger of obsolescence. For the time being, I am content to leave the (sometimes formidable) problem of inter-instrument reliability to the technologists. Today, there is no adequate substitute for the personal psychomotor skills of the physician in physical diagnosis in spite of his frequent fallibility. This fallibility reflects a major weakness in medical education.

I feel that the contributions of Lawrence Weed, MD, are too important to be lightly dismissed as in the reference to "SOAP-ing" the record. "Significant impoverishment" can be accomplished using anyone's medical record system. I am aware that I and my colleagues have carelessly abused the Weed Problem-Oriented Medical Record in our attempts to apply it to our practices. As Dr. Stephens points out, this reflects more on our clinical wisdom than on the problem-oriented record system itself. As Dr. Weed pointed out, the construction of the problem list is of central importance in the system. The definition and redefinition of problems and, as Dr. Stephens suggests, their prioritization is a most crucial test of clinical wisdom. In medical education, there are few such opportunities for experienced clinicians to assess and assist the medical student.

I do not share Houston's enthusiasm for the proper use of the placebo. In my view, such manipulative deception is for charlatans. But here is a dilemma. Dr. Stephens says, "the placebo response occurs in relation to all modes of therapy and restrains undue enthusiasm for all new treatments." For physicians not to be conscious of this effect undermines their effectiveness and compromises their ability to learn from experience. So, I advocate a knowing and intelligent use of the placebo response. But not sugar pills, for heaven's sake! I am just short of horrified that one of Dr. Stephen's educational objectives for teaching clinical wisdom includes the use of placebo *medication.*

I consider my own medical philosophy to be a viable alternative to the nosological approach to the practice of medicine, which I feel has limited practical applicability. Therefore, I would take exception to two more of the nine educational objectives. In my clinical experience, psychiatric labeling has been nonproductive. To insist that classifying patients according to obsessive-compulsive, hysterical, paranoid, etc, as an application of clinical wisdom almost leaves me gasping in shock. On the other hand, I share Dr. Stephens' sense of importance of the psychodynamic factors in health and disease.

Fred L. Mitchell, Jr., DO
Department of Biomechanics
College of Osteopathic Medicine
Michigan State University
East Lansing

Continued on page 734

Continued from page 732

The preceding letter was referred to Dr. Stephens who responds as follows:

In response to Dr. Mitchell's letter, I do not feel that we have substantial disagreements. The paragraphs referring to "quacks and nostrums" and "doctors of the people" was meant to be descriptive of the situation around the turn of the century and was in no sense a defense of one "brand" of medicine against all others. As a matter of fact none of the healing professions were scientific until after the establishment of the germ theory. I agree with Dr. Mitchell that the germ theory did not eradicate quacks and nostrums and that it is not an adequate explanation for all human illness, but it was a *model* of disease that was revolutionary in its effect on medicine and society. The point I wanted to make is that the AMA organized much of its reform activity around this issue in the early decades of the 20th century. (I am already on the record in this Journal in regard to the philosophical inadequacies of biological reductionism as an outgrowth of the germ theory *(J Fam Pract 2:423, 1975)*.

Dr. Mitchell's comments on the "clinical wisdom" paper are largely editorial and do not require a response except for his "horror" at my suggestion that a student be taught to use a placebo medication. I have been criticized about this by others and I am ready to change my mind and withdraw that objective. What should be substituted is an objective requiring the use of suggestion as a therapeutic method and perhaps another built around the recognition and use of the placebo effect. I have not tried to formulate these in precise language but I think it can be done.

Finally, in spite of Dr. Mitchell's "gasping in shock" about my objective on personality diagnosis, I will stick to my guns on this one, and to support my position I refer him to MacKinnon and Michels *(The Psychiatric Interview in Clinical Practice. Philadelphia, WB Saunders, 1971)* and to Shapiro *(Neurotic Styles. New York, Basic Books, 1965)*. Mainstream psychiatry has long since abandoned the notion that one does not have to make a diagnosis in order to treat the patient. Only those who have an antihistorical bias believe that you can ignore the past, which is what diagnosis is all about.

I appreciate Dr. Mitchell's taking the time and effort to comment on my paper. I feel that we have much in common in our understanding of human illness.

G. Gayle Stephens, MD
School of Primary Medical Care
University of Alabama
Huntsville

Erythromycin in Staphylococcal Infections

To the Editor:

In reference to the article by Stephen D. Boren, MD *(Treatment of Staphylococcal infections. J Fam Pract 4:1163, 1977)*, I take exception to the unreferenced statement regarding twice daily dosage of erythromycin for the treatment of staphylococcal infections.

According to Weinstein,[1] peak plasma concentrations are achieved in one to four hours following oral administration of erythromycin base or the stearate. He states further that these concentrations decline strikingly by the fourth to sixth hour. The serum half-life of erythromycin has been reported to be between three to six hours.[2]

Based on the assumption that the maintenance of therapeutic concentrations of an antimicrobial agent will achieve greater cure rates from bacterial infection, the administration of erythromycin every 12 hours seems

Continued on page 738

Continued from page 734

inadequate. Please provide a reference which compares cure rates of staphylococcal infection following twice daily dosage of erythromycin with four times daily administration as recommended by the manufacturer in their product literature.

Theodore J. Anderer, Pharm D
Pharmaceutical Profile Center
The Williamsport Hospital
Williamsport, Pennsylvania

References

1. Weinstein L: Antimicrobial agents: Miscellaneous antibacterial agents. In Goodman LS, Gilman A (eds): The Pharmacological Basis of Therapeutics, ed 5. New York, Macmillan, 1975, pp 1224-1227
2. Baude AI: Antimicrobial Drug Therapy. Philadelphia, WB Saunders, 1976, p 68

The preceding letter was referred to Dr Boren who responds as follows:

Dr. Anderer is indeed correct about the serum half-life of erythromycin base and erythromycin stearate. However, erythromycin estolate has higher serum levels and these high levels persist longer.[1,2] Prolonged serum levels (3mcg/ml at six hours) have been demonstrated using the estolate form.[2]

The use of the estolate form has been associated with cholestatic hepatitis. However, this starts 10 to 20 days after treatment and resolves on discontinuing the medicine.[1] Also, the overall incidence of this problem is very low. Only 200 cases were reported in the 1966-1974 period.[3]

There is no question that one needs prolonged elevated serum levels of erythromycin. Unfortunately, many patients will not take pills four times a day. The problem of patient compliance is too great for even a short review. Unlike patient treatment at large teaching hospitals, lack of improvement of a patient in a primary care center in a small community hospital frequently reflects noncompliance rather than an erroneous choice of medicine. I feel that there is a definite place for erythromycin given twice a day. The benefits far outweigh the possible side effects.

Stephen D. Boren, MD
Clinton Hospital
Clinton, Massachusetts

References

1. Winstein L: Antimicrobial agents: Miscellaneous antibacterial agents. In Goodman LS, Gilman A (eds): The Pharmacological Basis of Therapeutics, ed 4. New York, Macmillan, 1970, pp 1275-1276
2. Bechtol LD, Stephens VC, Pugh CT, et al: Erythromycin esters — comparative in-vivo hydrolysis and bioavailability. Curr Ther Res 20:610, 1976
3. Marr J: Antibiotics and infectious diseases. In Dauber J, Boedeker E (eds): Manual of Medical Therapeutics, ed 21. Boston, Little, Brown, 1974, p 201

Drug Therapy of Hypertension

To the Editor:

I thoroughly enjoyed Grissom and Gust's article *Prevention of some complications of essential hypertension. (J Fam Pract 4:831, 1977)* and would like to call your attention to what must be a misprint contained in Table 2 on page 833. The table indicates that *methyldopa* is to be avoided in patients with lupus erythematosus. I know of no such contraindication although the contraindication of hydral-

Continued on page 739

Continued from page 738

azine in these patients is well established.

William Bookheim, PA-C
Madison Area Health Center
Madison, Maine

The preceding letter was referred to Dr. Grissom who responds as follows:

I wish to thank William Bookheim for his observation that hydralazine is the more appropriate drug to have shown as contraindicated in the presence of lupus erythematosus.

In point of fact, methyldopa also has been associated with both the positive lupus test and with the rheumatoid factor test, first reported 20 years ago.[1] It is known that rheumatic symptoms with methyldopa in the absence of the positive antinuclear antibody test are not rare. Also serious instances of chronic active hepatitis,[2] presumably on a similar hypersensitivity basis, have been described, some suggesting lupoid hepatitis. Abnormal proteins, not of the lupus type, are associated with the Coombs test, which has been reported in a frequency of 20 percent in patients taking it on a chronic basis.

Goodman and Gilman in their 1975 edition[3] of *The Pharmacological Basis of Therapeutics* report lupus as a complication of methyldopa. Nevertheless, it is uncommon in comparison with hydralazine which should have been mentioned in our report as contraindicated with lupus. In such a patient, I would recommend neither one, but certainly hydralazine is far more important.

Robert L. Grissom, MD
University of Nebraska
Medical Center
Omaha, Nebraska

References

1. Sherman JD, Love DE, Harrington JF: Anemia – positive lupus and rheumatoid factors with methyldopa: Report of three cases. Arch Intern Med 120:321, 1967
2. Goldstein GB, Lam KC, Mistilis SP: Drug induced active chronic hepatitis. Am J Digest Dis 18:177, 1973
3. Goodman LS, Gilman A: The Pharmacological Basis of Therapeutics. New York, Macmillan, 1975