

## Part 5. Psychologic Reactions During Hospitalization: Their Evaluation and Management

In the instance of serious illness that requires hospitalization, the prospective patient must not only recognize his need for medical help and seek it, he must also temporarily relinquish his customary social role upon entering the hospital, adapt to the complexities and uncertainties of life in a modern hospital, and, during convalescence, relinquish the sick role and return to his pre-illness position in society to the extent that recovery allows. Usually this whole process, though always accompanied by emotional reactions of various sorts and degrees, proceeds without a serious hitch. Sometimes, however, emotional reactions and behavior patterns do develop which seriously threaten to compromise treatment and impede recovery; these reactions constitute genuine complications of the illness or treatment and require thoughtful evaluation and management.

### Some General Features of Hospitalization

The hospitalized patient is confronted with the prospect of placing himself almost totally in the care of people who, with the possible exception of his personal physician, are apt to be complete strangers. In the hospital he loses control over many aspects of his daily life: other people or hospital routine determine when he wakes up in the morning, when and what he eats, when and how many people may visit him, whether he stays in bed or not; physical examinations, laboratory procedures, x-rays are scheduled for him, sometimes without his knowledge; medicines are "ordered." He is apt to have much less privacy than he is accustomed to; nurses, nurses' aides, students, interns, residents, technicians, and his attending physician may pop into his room at all hours of the day (and evening) with or without a warning knock.

He is subjected to a number of procedures which have a "leveling" effect: certain personal belongings are removed for safe-keeping; he is tagged with a wristband, clothed in a short gown more or less open in the back; he endures repeated history-taking and physical examination by assorted persons (especially in a teaching hospital); has various body orifices inspected and probed, is carted here and there by wheelchair or stretcher; and in general he is in a relatively passive position of having things done to him which he often does not understand by people who frequently are in a hurry and who may seem to him to be more concerned with other patients who are more ill than he.<sup>13</sup>

### Separation

Hospitalization usually separates the patient to a considerable degree from the important people in his life and from customary sources of satisfaction in recreation and work. Socially and vocationally, the hospitalized person is temporarily "out of the running" for in a sense he must step aside while life goes on. While some patients welcome this aspect of the experience, perceiving it as a needed respite, many others feel saddened, grieved, or fearful that the presumably temporary separations caused by hospitalization may turn out to be permanent. The latter threat may arise from consciously entertained possibilities of death or invalidism or it may be connected with a fear of being replaced, eg, by an ambitious younger person who is pinch-hitting for the patient at his place of employment.

### Reunion

As with illness itself, hospitalization may afford the patient considerable psychologic gratification. The fact of being seriously ill allows the patient an opportunity for socially approved

passivity and dependence. In addition, members of the family may "gather around" and, in various ways, show their love and concern for the patient. Sometimes old rifts between the patient and relatives or friends are closed, at least temporarily, and the patient's illness brings about a kind of family reunion. Perhaps these psychologically "positive" aspects of illness and hospitalization contribute to an interesting phenomenon that psychiatrists have often observed, namely, the sometimes striking remission shown by schizophrenic patients who become physically ill. Temporary improvement may also be seen in other types of emotional disorder when physical illness intervenes.

A 65-year-old widower had suffered for many years with a severe obsessive-compulsive neurosis. A great deal of his waking life was taken up with innumerable, complicated obsessions and rituals. In the course of time, he had become estranged from his two children, partly because they found his constant worrying and ritualistic behavior difficult to tolerate. As the patient's estrangement from his children progressed, he became more and more concerned that certain thoughts (obsessions) which came into his mind would cause something terrible to happen to them. He really knew that this could not be so, that one person's thoughts could not harm another person. But the anxiety was there nonetheless and the patient was compelled to engage in lengthy prayers and other rituals to protect his loved ones from harm.

When the patient developed an acute intestinal obstruction, requiring emergency surgery, his children became very concerned. Their relationship with the patient changed. Instead of being icy, hostile, and distant they manifested much warmth, visited him frequently throughout his hospital stay, and kept closely informed about his condition. Throughout the period of hospitalization, the patient was impressively less beset with obsessions and compulsions than he had been for many years. Following hospitalization, many of the old obsessive-compulsive symptoms returned, as did the estrangement from his children,

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though not to the degree that existed prior to the surgical illness.

### *Uncertainty*

There is always some degree of uncertainty in the patient's mind regarding the danger to life and limb, duration of hospital stay, the likelihood of pain and other suffering, and the ultimate outcome of his hospital experience. While it is true that it is beyond the power of the physician to totally remove the patient's uncertainty (for this would be tantamount to removing reality), it is within his power to engage the patient in matter-of-fact discussions about his experiences and concerns; this is done, not with the aim of completely alleviating anxiety or a harmless defense against anxiety such as the noninterfering use of denial, but for the purpose of correcting distortions and supplying the patient with information which realistically enhances feelings of security and hope.

During the course of hospitalization, especially if occasioned by prolonged, severely incapacitating, or life-threatening illness, the patient almost invariably undergoes some degree of regression and develops a relationship with the physician which is heavily colored by transference.

### *Transference*

Transference is the displacement of feelings and attitudes from important relationships in earlier life to someone in the present. The rapid development of intense transference in the hospitalized patient's relationship with physicians and nurses is fostered by several factors.

1. In terms of the degree to which the patient is utterly dependent upon others, the experience of hospitalization more closely resembles that of infancy or childhood than does almost any other situation of adult life. As a result, old feelings, expectations, and attitudes, deriving from the dependency situation of early life, are mobilized and manifested in overt or disguised form in the patient's relationships with those currently caring for him. That is, the patient is now "in the hands" of the physician and nurse as he had once literally and figuratively been in those

of his parents. Old issues of trust or distrust, of being cooperative or rebellious ("doing what he is told," being a good boy or good patient), of perceiving those in whose charge he now is as loving, caring, reliable, and competent or the reverse are to some extent reexperienced.

2. As already noted, the chances are that many or all of the staff are strangers to the patient and even his attending physician may be relatively unknown to him. This relative anonymity of the physicians and nurses facilitates the patient's imparting to them attributes derived from earlier experiences with authority figures, especially his parents. The patient is also apt to draw upon his prior experiences with other physicians and nurses in making assumptions about those with whom he is currently dealing.

The two preceding sets of factors combine to promote intense transference: being in a position of extreme dependence upon the physicians and nurses for his comfort and for his very survival, the patient almost invariably has some measure of anxiety. This anxiety is allayed considerably by the development of a strongly positive transference in which the patient imputes to the physician (and others who are perceived as critically important to his welfare) the omniscient and omnipotent qualities which his parents seemed to possess when he was a small child. In other words, the hospitalized person's situation is such that he needs to feel that his physician is the best and is totally committed to his welfare. In this connection, physicians have repeatedly noted that often the patient regards what the physician says as virtually infallible, even though the patient may actually know very little about the physician. This faith in the physician may have a very powerful therapeutic influence. It is possible, for example, that some of the early success with internal mammary artery implantations was a result of the patient's faith in the surgeon rather than myocardial revascularization.<sup>24</sup> Positive transference, even when it entails rather obvious overvaluation of the physician, does not ordinarily pose a problem, is psychologically useful to the patient, and the physician does well simply to accept it.

There may, however, be transference reactions of a negative nature. Warning clues to this type of transference

are obtained when the patient, in relating his history, reveals a pattern of being critical of other physicians who have cared for him in the past. It may not be possible to prevent the development of negative transference. If the patient becomes resentful, distrustful, and critical it is important to assess the possibly realistic justification for his feelings. If such an assessment, which should include not only the physician's own dealing with the patient but other factors including attitudes of other members of the staff, leads one to the conclusion that the patient's negative criticisms are unrealistic or overdone, it is quite possible that one is observing transference distortions. Recognition of this possibility helps the physician to maintain professional objectivity, to be tolerant of the patient's feelings, and to engage him in discussion of them. Usually, however, it is not helpful to attempt to interpret the childhood origins of transference feelings to the patient.

### *Regression*

In the course of prolonged hospitalization and severe illness, many patients revert to forms of behavior, feelings, or modes of thinking which were characteristic of them at a much earlier stage of life. Strictly speaking, intense transference is itself a type of regression. Regression in hospitalized patients may take many forms depending upon its severity and upon defensive reactions to anxiety engendered by the regression.

Regression, in its moderate and more usual form, represents an understandable, useful adaptation to hospitalization. The patient becomes quite centered upon himself, especially upon his physical sensations and symptoms, comes to rely extensively upon others to meet his needs, and accordingly may develop unrealistic expectations of response by the staff to his complaints or requests. He is therefore more upset by minor provocations than normally and, as described above, may derive considerable comfort by exaggerating the competence, dedication (to the patient), and general goodness of his physician and other members of the staff. The patient who comfortably experiences

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the regressed, dependent state often becomes irritable during the recovery phase when he is called upon to relinquish the legitimized gratifications afforded by the illness.

Not all patients experience regression comfortably. The patient may feel quite threatened by his own dependency needs, or may lack a sense of basic trust in those who care for him and may therefore need to assert his autonomy. For these and other reasons, a variety of complicating behavior patterns may emerge in the course of hospitalization. These will be discussed later in this chapter.

### Special Clinical Situations

#### *Intensive Care Areas*

In response to the needs of critically ill patients and to the advantages of concentrating advanced equipment and specially trained personnel in defined areas within the hospital, intensive care units (ICU) and coronary care units (CCU) have been widely developed. These intensive care areas have proven their usefulness in critical care medicine. It has become recognized, however, that the incidence of serious psychologic disturbance among patients in these units is relatively high and, further, that the emotional stress experienced by the staff, especially nurses, is greater than that in other parts of the hospital.

Although the term "ICU syndromes" has been used to refer to the mental or emotional disturbances observed in intensive care patients, it does not appear that there is a qualitatively unique syndrome that characterizes these disturbances. In intensive care areas, as elsewhere in the hospital, patients may develop anxiety, depression, delirium, and paranoid states, and may present a wide variety of behavioral problems which require management. The relatively high incidence of psychologic disturbances in these areas is apparently due to a number of factors as described by McKegney,<sup>20</sup> Kornfeld,<sup>15</sup> Cassem and Hackett,<sup>5</sup> and others.<sup>10</sup>

#### **Illness-related Factors**

Patients are not admitted to intensive care areas, of course, unless they

are very seriously, usually critically, ill. If cardiac arrest, respiratory cessation, or shock has occurred at any point in the course of illness, the resulting cerebral anoxia may affect cognitive functions and behavior, depending upon its severity and duration. Numerous other physiologic consequences of illness such as hyponatremia, hyperkalemia, hypoglycemia, and uremia may profoundly alter higher cerebral function.

With the growing population of older persons, it is to be expected that a substantial number of patients in intensive care areas are elderly and have some degree of cerebral impairment due to senile and arteriosclerotic processes. These patients are predisposed to an acute brain syndrome superimposed on their chronic conditions. The use of barbiturates in elderly patients may be associated with increased confusion and agitation.

A minority of patients admitted to intensive care units have self-inflicted wounds or have taken drug overdoses. The emotional or behavioral conditions which led to the suicidal attempt become part of the clinical picture when the patient regains consciousness.

The psychologic meaning of the acute illness to the individual patient is of extreme importance in determining emotional and behavioral reactions. In describing their extensive experience with psychiatric consultations on a coronary care unit, Cassem and Hackett noted that anxiety reactions tend to occur most frequently on days 1 and 2 in the CCU, depression on days 3 and 4, and that behavior-management problems had a bimodal distribution, peaking on days 2 and 4.<sup>5</sup>

These authors have accordingly described a "natural history of the emotional reactions" of normal persons to myocardial infarction. Upon admission to the CCU, having just experienced life-threatening, crushing chest pain, the average person feels considerable anxiety. With symptomatic improvement, particularly if evidence of cardiac damage is equivocal, denial is mobilized and the patient may protest hospitalization and insist upon returning to work (the first peak of "management behavior problems"). By the third or fourth day, the average patient with a confirmed diagnosis of

myocardial infarction becomes more aware of the implications of his condition and despondency often occurs. At this point, some patients with conflicts centering on dependency and passivity begin to display irritating, provocative behavior.

### Environmental Factors

The physical design and atmosphere of intensive care areas vary considerably from one hospital to the next and increasingly have received thoughtful attention as the importance of environmental stresses on patients and staff has become apparent. Nonetheless, in many intensive care areas, the patient is surrounded by a physical setting which may seem strange and frightening to him. The patient is apt to be deprived of normally present, orienting sensory cues such as clocks, newspapers, windows, and a regular schedule of meals. On the other hand, he is overloaded with sensory stimuli which may be quite anxiety-provoking such as the visual and auditory signals of monitoring equipment, the occurrence of crises which summon physicians and nurses to a nearby bed or room, deaths of fellow patients, and the general tension that sometimes pervades the atmosphere of an intensive care unit. The patient may be almost immobilized by tubings of various sorts and wires connecting him to equipment. The overhead light may remain on, physicians and nurses are at his side frequently to perform necessary chores, and he hears the moans and groans of other patients. In this environment, the patient may be seriously deprived of sleep for several days or more. The combination of sensory monotony, sensory overload, and sleep deprivation further predisposes the patient to the development of emotional disturbances and confusion.

It should also be noted that the availability of sophisticated monitoring equipment, vital though it is, can result in the substitution of telemetry for personal contact between staff and patient; this is particularly apt to occur when the unit is unusually busy or understaffed.

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### *Hemodialysis for Chronic Renal Failure*<sup>4,7,8,14</sup>

Although patients who receive ongoing dialysis for chronic renal disease are usually managed only partially or intermittently in the hospital, it is convenient to consider some of the psychologic aspects of this form of treatment in this chapter. The stresses undergone by these patients usually are severe and stem in part from the effects of the underlying renal insufficiency and in part from the treatment regimen. The latter requires the patient to conform to rather strict dietary restrictions and to two or three times weekly dialysis sessions which are time-consuming, inescapable, and sometimes alarming to the patient (especially the novice) who is aware that a portion of his blood is out of his body and in the machine during the procedure. This whole situation forces the patient not only to modify his daily life in conformity with treatment requirements but also to be dependent upon the personnel of the dialysis unit or, in the event of home dialysis, his wife or other helper.<sup>26</sup>

The ability to tolerate the restrictions, changes in life routines, and dependence on the machine and people varies a great deal from one person to the next. Some persons repeatedly deviate from the treatment program in ways which are deleterious or life-threatening, others conform but become excessively "dialysis-centered," and still others seem to do what is necessary and continue actively to pursue their goals and interests which may be modified to suit their current situations.

Most patients requiring dialysis are uremic to some degree at one or more times in the course of their illness, and during uremic episodes higher cerebral function is frequently impaired sufficiently to produce an acute (reversible) brain syndrome or delirium. This condition may at times be mild enough that it is only detectable by doing a mental status examination. Impairment of orientation, memory, and other cognitive functions prevents the patient from resuming certain kinds of activities if he is discharged from the hospital and may also interfere with his grasping and retaining instruc-

tions given to him about the dialysis procedure, diet, and other aspects of management.

The patients often feel tired and weak, and are confronted with a basically unending, incurable disorder though they may live in hope of receiving a kidney transplant or of future technical improvements in the dialysis procedure. Kidney transplantation itself is loaded with grave uncertainties and the hope for a kidney to become available may even be tinged with guilt if it entails the accidental death of the future donor. In the meantime, the dialysis patient may be caught in a situation of not being clearly well or clearly sick. He is, as Landsman has pointed out, a "marginal man."<sup>16</sup>

Somewhat surprisingly, in view of the severe stresses impinging upon these patients, the incidence of overt, psychotic disturbances does not appear to be high. Not surprisingly, many patients, especially those whose occupations have required much physical activity, find it very difficult to find a productive, satisfying role for themselves. Some patients become depressed. Wise has pointed out, however, that there is a "pitfall" to be avoided in diagnosing depression in patients with chronic renal failure, ie, apparent depression may be correlated with the presence of uremia and may lift as the uremia is alleviated by treatment.<sup>27</sup>

### **Surgery**<sup>9,17,22,29</sup>

Patients who undergo surgery and require postoperative care in a recovery room for a substantial period of time are, of course, exposed to the psychologic stresses already described for all ICU patients. In addition, there are special aspects of the surgical patients' experience which merit attention. These include the particular features of the illness or conditions for which surgery is required and of the operation itself.

If the illness has been of long duration and has been utilized for the avoidance of anxiety or for other psychologic gain, there may be considerably difficulty in rehabilitation following successful surgery. Through the development of new symptoms or the continuation of old ones, a substantial degree of invalidism may persist in spite of good physiologic results from

surgery. This was observed, for example, by Kaplan<sup>12</sup> in his study of patients who underwent mitral commissurotomy and by Eifrig et al in patients following pericardectomy.<sup>6</sup> On the other hand, those patients who have a history of continuing difficulty in adapting to or accepting the incapacitation of illness may quickly reestablish pre-illness patterns of living after successful surgical intervention.

It is not rare for patients with deep-seated emotional problems to develop somatic complaints and actively to seek a surgical operation. While there may be transient symptomatic relief, the underlying problems remain unaltered and new symptom formation usually occurs. Thus it is not rare for the patient with long-standing or recurrent conversion hysteria to have a history of polysurgery.

Occasionally the performance of surgery to correct a psychogenic symptom may precipitate emotional decompensation. This may be particularly apt to occur when the patient's psychologic problem is expressed in one major physical symptom such as preoccupation with an objectively minimal cosmetic deformity of the nose (especially in males) or impotence.

While it is reasonable to assume that there is always some degree of anxiety prior to surgery, there does not appear to be clear evidence of a positive correlation between degree of overt preoperative anxiety and emotional disturbance in the postoperative period. It may well be, however, that denial of anxiety preoperatively is associated with a greater likelihood of subsequent psychologic disturbance. In addition, patients who believe they will die during or following the operation may carry a higher risk of fatality than do patients who believe they will survive. In the former instance, surgery should be delayed, if possible, and psychiatric consultation obtained.

The surgical procedure itself may have actual or symbolic consequences which pose considerable stress for the patient. Loss of a limb, mastectomy, colostomy, orchidectomy, and hysterectomy are among surgical procedures which may result in the patient's

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feeling functionally diminished, unworthy, incomplete, or unlovable as a man or woman.<sup>18</sup> In such patients it is not rare for depression to occur days, weeks, or months after the operation.

Postoperative psychosis with evidence of acute organic brain syndrome is not rare. Its incidence is increased by any procedure which enhances the likelihood of compromised cerebral function such as prolonged anesthesia, cardiac bypass in open-heart surgery, and the use of barbiturates, especially in the elderly. The presence of chronic brain syndrome, commonly present in older patients, enhances the likelihood of postoperative delirium. Not rarely, a patient with undiagnosed alcohol or barbiturate addiction develops an unexpected withdrawal syndrome following surgery.

### Psychologic Disturbances

Effective management of patients who develop psychologic disturbances in the course of hospitalization rests upon accurate diagnosis, including the discernment of significant etiologic factors. As Albert and Kornfeld have pointed out in their study of patients who threatened to sign out of the hospital against medical advice, early diagnosis and prompt intervention may serve to prevent the development of serious behavioral disturbances.<sup>1</sup> Early detection is thwarted by breakdowns in communication between the staff and the patient and between members of the staff.

The variety of psychologic disturbances observed in hospitalized patients is considerable and depends in part upon the patient's personality or characteristic modes of coping with stress as well as upon the nature of the particular stresses to which he is currently subjected. The following is a brief review of some of the more commonly observed psychologic difficulties experienced by medical and surgical patients.

#### Anxiety

The anxious patient may be restless, tend to glance frequently around the room or toward others as if he is hyperalert, have sweaty palms and tremor, look worried or apprehensive,

and have difficulty in relaxing and falling asleep. He may at times appear tensely rigid. The specific content of fears and apprehension may be revealed in spontaneous remarks by the patient or in response to tactful inquiry of a sort which conveys a certain empathy by the questioner.

#### Depression

Sad or expressionless faces, slowness of motor behavior and speech, apathy or apparent lack of interest, anorexia, difficulty in falling asleep, fitful sleeping, and early awakening all point to the presence of depression. The patient may or may not verbally express feelings of depression or sadness, pessimism, hopelessness or despair, and worthlessness. Some depressed patients may keep such feelings to themselves for fear of alienating physicians and nurses, especially if they are perceived as being concerned only with the physical aspects of the patient's illness. Not uncommonly, symptoms of anxiety and depression occur together.

#### Acute Brain Syndrome

Reversible impairment of cognitive (including perceptual) functions, often accompanied by varying degrees of excitement and fear, may occur in a wide variety of medical and surgical illnesses. Disorientation and memory impairment are often not discernible on casual observation and may only be detected by doing a mental status examination. The timing of the examination is important since delirium is often characterized by marked waxing and waning, exacerbations frequently occurring in the evening. Frightening illusions and hallucinations involving visual, auditory, and tactile modalities and paranoid delusions which are poorly systematized and changeable may occur.

#### Psychosis Without Apparent Organic Basis

In predisposed individuals grave psychologic decompensation may occur even in the absence of physical impairment of higher cerebral function. Hypomanic states manifested by hyperactivity, hypertalkativeness, and euphoria or irritability are occasionally seen. Paranoid states, manifested by extreme distrust and delusions of be-

ing watched, poisoned, or conspired against may sometimes develop. These severe states of psychologic decompensation may result from conflict between defensive behavior patterns and the immobilization or enforced dependency imposed by the treatment situation. Less commonly they are precipitated by the inadvertent compromising of crucial defenses through symptom removal.

#### Miscellaneous Behavior Problems

There are a number of behavior management problems which defy traditional classification and which may be associated with all of the psychologic disturbances described above.

#### Uncooperative Behavior

Intense anxiety, with or without organic cerebral impairment, can evoke defensive denial of illness and therefore of the need for treatment. Grave suspiciousness, delusional mistrust, understandable misinterpretation of environmental cues, and confusion may lead to anger and fear which are manifested by refusal to cooperate with the staff or by threats to sign out against medical advice. More rarely, the depressed patient may be uncooperative because he feels his condition is hopeless or that he is unworthy of treatment. *The associated emotional disturbance is usually manifest before the eruption of blatantly uncooperative behavior or threats to sign out.*

#### Self-destructive Behavior

Behavior with potentially injurious or lethal consequences is frequently seen in delirium. Impaired judgment, relatively poor impulse control, and panic may lead the delirious patient to pull out intravenous tubing, strike at the nurse or aide, wander from his room, or jump out a window. Planned, deliberate suicide attempts, on the other hand, are usually associated with depression.

#### Complaining and Demanding Behavior

The patient who complains of symptoms which are out of proportion to the organic illness or which have no organic base at all quickly becomes

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regarded as a "crock." Excessive symptomatic complaints may or may not be associated with other complaints related to the diet, service, room temperature, staff attitudes, or some other feature of the hospital. Generalized complaining is usually associated with "demandingness," the patient asking the staff at all hours of the day or night to give him something he needs or to correct some allegedly intolerable deficiency.

Complaining, demanding behavior often arises from covert anxiety in that it reflects the patient's insecurity and his need constantly to reassure himself that someone is available and responsive to his needs. This type of behavior may also arise from the patient's need to exert control over his environment and thereby to recapture a measure of the autonomy which was his prior to hospitalization. Complaining and demanding behavior may be an expression of thinly veiled anger, distrust, and a desire to manipulate staff members.

Ironically, the behavior usually has a "positive feedback" effect in that it alienates the patient from the staff and thus may result in a degree of actual neglect which then fuels further complaints and demands.

### **Sexually Provocative Behavior**

The patient whose self-concept, particularly his image of himself as a virile male, has been threatened by real or imagined consequences of the illness may attempt to bolster self-esteem by engaging in a variety of sexual overtures directed toward the nurses and female physicians. This behavior may take the form of jokes, making passes at the nurse, and exhibitionism.

## **Management<sup>2,3,9,11,19,22,23,25</sup>**

### *Patient-Physician Relationship*

#### **Confidence and Rapport**

Of basic importance in general medical management and in minimizing the likelihood of severe emotional disturbance is the establishment of a physician-patient relationship in

which confidence, trust, and open communication are fostered. Experienced physicians and nurses often convey the all-important fact of their technical competence through an unaffected professional manner of unruffled, sometimes casual self-assurance in their dealings with the patient. Each experienced clinician has his own unique way of establishing rapport with the patient and knows the value of informing him in clear, understandable language of diagnostic and treatment plans and progress.

#### **Tailoring Approach to Patient's Personality<sup>2,3</sup>**

It is clear, however, that the way the physician relates to the patient is not only influenced by the physician's own personality but also by the personality and current emotional needs of each individual patient. Bibring and Kahana<sup>3</sup> have pointed out the usefulness of tailoring one's approach according to the salient characteristics of the patient's personality and the value of utilizing one's knowledge of important psychologic needs in influencing the patient's behavior. For example, the suspicious, paranoid person responds best to an approach of firmness, accuracy, and careful avoidance of ambiguities. The schizoid person can be expected to be somewhat aloof and distant; the physician, while encouraging him to ask questions or to clear up any matter about which he may be doubtful or worried, nevertheless respects the schizoid patient's need for privacy. The obsessive-compulsive person tends to reduce anxiety by learning all the facts and attaining intellectual mastery of situations; the physician can help such a patient to meet these needs by judicious review of clinical procedures and of the various relevant aspects of the hospital environment. On the other hand, the excitable, histrionic, or hysteric patient, while certainly needing to be informed of the essential facts of his clinical situation, may be in greater need of an opportunity to ventilate his feelings, fears, and fantasies. The patient who has always taken pride in being strong, self-sufficient, and in control can be tactfully reminded that he plays an active role in the treatment process and that in going through hospitalization and

treatment he is doing his part to get back on his feet; the physician further supports this type of patient by eliciting his opinion about various issues relating to the clinical situation and utilizing those suggestions which have validity.

#### *Physician's Response to Denial*

As noted elsewhere, denial may be a useful coping response which gains the patient time to muster his resources and tides him over a particularly frightening phase of the illness experience. An example of this is the person who, while complying with the treatment regimen, displays an affect of cheerfulness, as if the full impact of his illness has not yet sunk in. In this situation, the physician does well simply to refrain from challenging the denial. He judiciously supports the patient's morale but is careful to avoid being unrealistically optimistic.

Denial that leads to overt disavowal of the fact of illness or which is manifested by behavior that implies disavowal can pose extremely difficult management problems for which there are no simple solutions. In these instances psychiatric consultation is often indicated.

The psychologic approach to the patient who presents a behavior problem stemming from denial of illness and of need for treatment includes tactfully calling to the patient's attention the fact that part of him must recognize his need for medical attention as evidenced by the fact that he did, after all, consult the physician, entered the hospital, and, depending upon the individual patient, has partially complied with treatment requirements. This represents an attempt to support the reality-testing part of the patient's ego and to nurture a sense of alliance between patient and physician. Depending upon the patient's response, the physician then attempts to help the patient deal with the fears or other feelings which have given rise to the denial. This may need to be done in graded steps and a logical place to begin is simply to ask the patient to talk about any troubling feelings or worries that may be bothering him, even if they do not seem to be connected with his illness. Psychia-

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trists have long observed that persons who talk about their feelings and fantasies with someone they trust are less likely to act upon them than are people who keep everything to themselves. The goal then is to foster the patient's verbalization of his ideas, fears, or worries and, when appropriate, to correct distorted concepts of the illness or treatment. Conceptual clarification of significant aspects of the patient's condition and treatment is an important part of management even when the patient is not engaged in treatment-interfering denial.

### *Conceptual Clarification*

It is wise never to assume that the patient has an accurate grasp of his illness and treatment and their implications. Some explanation to the patient of his condition and of what he can expect as treatment progresses is in order prior to or at the beginning of hospitalization. The completeness and detail of such an explanation are tailored to the situation and needs of the individual patient and should be followed by inviting the patient to inform the physician of any questions or concerns which arise. The variety of disturbing conceptual distortions which may arise in the course of serious illness is enormous. Some patients may secretly assume that cancer is never curable, that persons with heart attacks can never work again or engage in sexual intercourse, that prostatectomy always causes impotence, that the heart is weaker during sleep and therefore sleeping is dangerous, or that the low-voiced corridor conversations of rounding physicians carry some ominous implication. Sometimes the physician can anticipate distortions but more often he must learn of their existence from the patient; this requires a continuing attitude of interest in what the patient is experiencing.

### *Anticipating the Patient's Experiences*

It may strengthen the patient's ability to adapt to the various phases of the illness if he is given some forewarning as to what he is likely to experience. For example, the patient who has been told that he will have some pain in the postoperative period

and that he will be encouraged by the nurses to cough will know that these experiences are "normal" and that his surgeon, who predicted them, is in control of the situation. If the patient with myocardial infarction is informed that he will likely feel some weakness for a period of time after his discharge from the hospital, he will not be so dismayed by that symptom or so apt to interpret the weakness as evidence that his heart is weaker than either he or his physician had thought.<sup>28</sup>

### *Confrontation*

When the patient has been engaging in disturbing or provocative behavior it may be useful for the physician or nurse to confront him with what he is doing. The confrontation should be simple, direct, matter-of-fact, and should not be done in anger. The confrontation may be accompanied by some discussion of the possible reasons for and consequences of the disturbing behavior. For example, after pointing out his behavior to the complaining-demanding patient, the physician may comment that many patients need to assure themselves that the staff is on the job but that calling them for trivial reasons is apt to be self-defeating. When confrontation is necessary it is important to give the patient an opportunity to express his side of the problem, and occasionally it is helpful to clarify or modify the management plan.

### *Modification of the Management Plan*

To continue with the complaining-demanding patient, the physician will find it helpful to discuss the behavior problem with the nurses and other members of the staff who have the most contact with the patient. Staff resentment should be aired and resolved, which may not be too difficult if the nurses are aware of the physician's interest and that he has discussed the problems with the patient. It may be useful, particularly when the demandingness is primarily serving to allay anxiety, for the physicians and nurses to make a point of making frequent, brief visits to the patient's room on a more or less regular schedule. The resulting display of interest and concern even when the patient has not called may remove the need to be demanding.

The patient who finds strict bed rest intolerable or who is threatened by passivity and dependence on others and is therefore trying to restore his sense of autonomy may be irritable, stubbornly negativistic, or resistant and generally difficult. It is often bolstering to the self-esteem of such a patient for the physician to discuss selected aspects of management with him and to elicit his ideas and suggestions. Working out a compromise therapeutic regimen with the patient may not only result in reducing the onerous aspects of treatment but may also give the patient a needed feeling of partial control or at least active collaboration with the physician.

### *Environmental Modification*

The environmental stresses described for intensive care areas often exist to some degree in other parts of the hospital as well. Careful attention to the patient's environment is important in the prevention and management of adverse psychologic reactions. All patients, particularly those who are delirious or are likely candidates for development of delirium, should be provided with individually appropriate, orienting, sensory cues such as a daily newspaper, a view of a window to differentiate day from night, frequent contacts with staff, and clear communication. If possible the patient should have a reasonable degree of privacy and should not be bombarded by disturbing stimuli such as the signals of his own monitoring equipment; the moans, groans, crises, and deaths of other patients; having an overhead light constantly on; and so forth. Careful attention should be paid to providing an environment in which the patient can get to sleep and, if possible, not be repeatedly awakened. If the patient is confused or suicidal, a responsible person should remain with the patient at all times.

### *Medication*

The overtly anxious, hospitalized patient often requires a minor tranquilizer such as diazepam (Valium), 5 mg to 10 mg bid or tid, and a mild sedative in the evening. It is useful to explain to the patient that he will be given the medicine for a few days and

Continued on page 900

that its purpose is to help him to feel less tense and more relaxed. Barbiturates should be used with caution since their use is sometimes associated with paradoxical excitement and increased confusion, especially in the elderly patient.

Antidepressant drugs may be indicated in depression and one of the major tranquilizers in psychotic states. The management of toxic psychoses secondary to withdrawal in cases of alcohol and sedative addiction requires administration of an appropriate substitute medication at adequate dosage with carefully graduated reduction over a period of days.

### Psychiatric Consultation

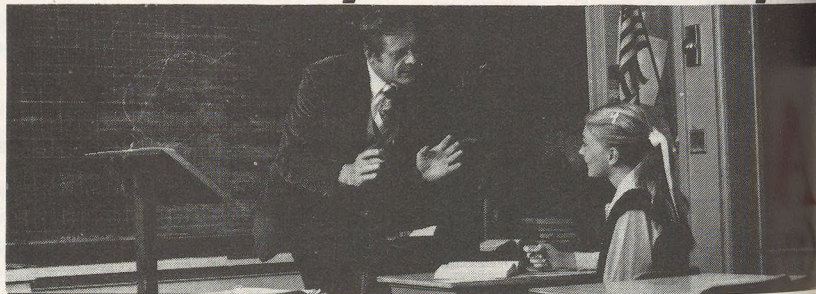
Psychiatric consultation is indicated in severe behavioral or emotional disturbances particularly when psychosis, marked anxiety, or depression is suspected or if the patient's behavior is seriously jeopardizing, directly or indirectly, the patient's safety and recovery. The utilization of the psychiatric consultant for disturbances of lesser severity depends on whether the primary physician feels the need for assistance in the development of a plan of management. Not rarely the emotionally troubled patient himself requests the consultation.

In any event, when the physician decides to request psychiatric consultation his first step is to discuss the need and potential usefulness of the consultation with the patient. The patient's receptiveness to the consultation, and hence its value, are enhanced if the patient understands at least some aspects of the problems for which the psychiatrist will see him. The psychiatrist himself will be more effective if he is thoroughly briefed by the referring physician as to the medical background and problems of the patient than if he sees the patient blind. Some patients may feel rejected and that their primary physicians are abandoning them to the psychiatrist. This can be averted by making it clear that the psychiatrist will function as a consultant to the primary physician who will continue to be responsible for the patient's care.

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When you are selling at a profit, cautions the P-H DOCTOR'S TAX REPORT, be certain that you are selling the option — and not the property. If, as sometimes happens, you exercise the option and sell the property forthwith, your gain is all short-term. Your holding period for the property does not start until the option is exercised. So the gain is taxable at ordinary tax rates — not the long-term capital gains rates you expected.

In a new Tax Court case: Anders acquired an option to buy over 80 acres of choice land for \$110,000. The option was good for five years and cost \$200 a month to keep open. These payments would be applied toward the exercise price if Anders exercised the option. A few months before the five years was up, Anders agreed to sell half the land for \$135,000 after he exercised the option. He took a check for \$5,000 from the buyers.

It seemed like a good deal to Anders — until he talked it over with accountant Holt, who pointed out that Anders could be in for big tax problems. And Holt was right. Anders' gain from the sale of the land would be a highly taxed, short-term gain. Reason: No sooner did Anders exercise the option and take possession than he turned right around and sold the land.

Holt suggested to Anders that he sell the option instead. That way, he would have tax-sheltered, long-term gain. Anders took Holt's advice. He returned the check to the buyers and sold the option to Holt for a substantial amount of money. Holt then exercised the option and sold the 40 acres to the original buyers. He continued to sell parcels of land and pay the purchase price of the option from the proceeds of the sale.

The government claimed that the whole thing was a sham: Holt didn't sell the land; Anders did. Holt was Anders' agent. Thus, Anders has a short-term gain from the sale of land, not long-term gain from the sale of an option. The Court held for a taxpayer victory. It is a valid deal from the start. Anders sold the option to Holt

and deserved long-term gain. The most telling point was that Holt, and not Anders, stood to make a healthy profit from the sale of the land. This was clearly a bona fide deal (Anders, 68 TC No. 41).

Seek professional counsel when deciding whether or not to sell your option before you enter into any agreements to sell land. Sell the option without any strings attached.

### Your Professional Library Represents a Top Tax Savings

How should you handle your professional library — those volumes, periodicals, and the like which are necessary in your practice — from a tax standpoint? Though the court cases and tax rulings are fairly hazy in this area, the government regulations do offer some help:

You may deduct the costs as current practice-connected expenses if the books, magazines, services, and periodicals have short useful lives. What is a short useful life? The Revenue Service says a usefulness of one year or less. Thus, outlays for books and professional loose-leaf services used for your practice, which are sold as annual subscriptions, may be currently deducted in year of purchase.

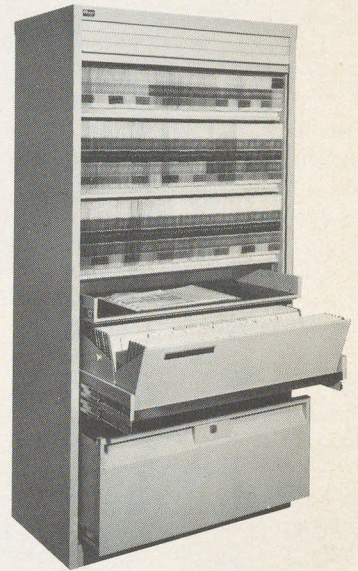
You have to capitalize and depreciate over their useful lives the cost of volumes which have a more-or-less permanent worth.

If you have an established library, chances are your annual additions of permanent volumes are limited in number and fairly nominal in total cost. Your big expense is probably for periodicals and other subscriptions which can be written off currently.

Continued on page 910

# MEDICON PRACTICE MANAGEMENT SYSTEM

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Suppose, however, that you acquired a brand new library this year, and it is almost entirely of permanent worth. Naturally, you would like to write the cost off as quickly as possible. Thanks to a three-way tax parlay, you may be able to recoup a large part of your investment in the very first year. To see how, P-H DOCTOR'S TAX REPORT gives this hypothetical example:

Let's assume you purchase a library for \$2,000 in January. Your top dollar is taxed in the 36 percent bracket.

1. Thanks to the Revenue Service's Class Life Asset Depreciation Ranges (ADR), you can set up an eight-year useful life for the books. Under the Revenue Service's guidelines, the useful life is ten years and the ADR system allows you to go 20 percent more or less than that figure. You are not bound by the guidelines if your actual replacement policy differs from them. Obviously, some books may prove useful for many years beyond the suggested "average." Others may be rendered obsolete in a relatively short time.

2. The books also qualify for the ten percent investment credit because they are tangible professional property with a useful life of seven years or more. That's a dollar-for-dollar savings.

3. The books also qualify for the 20 percent first-year allowance, since useful life is six years or more. Your \$400 ( $\$2,000 \times 20$  percent) first-year allowance is well within allowable limits.

4. Finally, to get the fastest possible writeoff, you elect to use 200 percent declining balance depreciation to write off the library. Based on an eight-year life your regular depreciation is 25 percent of the remaining basis — \$400 ( $\$1,600 \times 25$  percent). Here are your dollar savings for the year:

	Depreciation	Dollar Savings
10% investment credit	—	\$200
First-year allowance	\$400	144
200% declining balance	400	144
	Total dollar savings (First year)	\$488

Be sure to keep accurate records of your book purchases. As with any other deduction, you cannot write off the cost of your library unless you can prove your claim. And you cannot prove your claim unless you submit evidence of the books' cost. You must also have some record of when each book was acquired.

### Tax Writeoffs for Your Hospital Staff Expenses

You can write off the cost of hospital staff privileges and related expenses needed to acquire and build up a practice. But, how fast can you write off the costs? Can you deduct them immediately as a professional expense? Or must you amortize them over a period of years — say the remaining life of your practice? For leads to the answer, P-H DOCTOR'S TAX REPORT refers physicians and their tax counsel to a recent tax court case:

Dr. Stump was a pathologist who had a 20-year contract with a hospital. In return for pathology services, he received one third of the hospital's gross laboratory income. With 15 years still to go, Dr. Stump sold the contract to Dr. Smith. Smith paid Stump \$105,000 and deducted the amount on his tax return as an expense for seeking new employment. The Government disallowed the deduction.

The tax court's view is that Smith gets no immediate writeoff, because he is not an "employee" of the hospital. But — and this is important — he does not have to write it off over the rest of the time he is in practice either. Even though there is a good chance that the contract will be renewed, the Court said that the 15 years remaining in the present contract would be a reasonable amortization period (Smith, TC Memo 1977-223).

The above information on taxes is adapted from P-H DOCTORS TAX REPORT published bi-weekly by Prentice-Hall, Inc., Englewood Cliffs, NJ 07632. For information on subscriptions, please address inquiries to R. M. Shaw.

## HYCOMINE® SYRUP

**DESCRIPTION** Each teaspoonful (5 ml) contains:

Hydrocodone bitartrate 5 mg  
**WARNING: May be habit forming.**  
 Phenylpropranolamine hydrochloride..... 25 mg

**USUAL ADULT DOSE** 1 teaspoonful every four hours after meals and at bedtime (not to exceed 6 teaspoonfuls in a 24 hour period).

**ACTIONS** Hydrocodone bitartrate is an effective semisynthetic narcotic antitussive. Phenylpropranolamine is a sympathomimetic amine which provides nasal decongestion.

**INDICATIONS** To control cough and to provide symptomatic relief of congestion in the upper respiratory tract due to the common cold, pharyngitis, tracheitis, and bronchitis.

**CONTRAINDICATIONS** Hypersensitivity to any component of the drug. Should not be used in patients receiving monoamine oxidase inhibitors.

**PRECAUTIONS** Use with caution in diabetes, hyperthyroidism, hypertension, cardiovascular disease and in the aged. Since drowsiness and dizziness may occur, patients should be cautioned about driving or operating machinery.

Before prescribing antitussive medication to suppress or modify cough, it is important to ascertain that the underlying cause of the cough is identified, that modification of the cough does not increase the risk of clinical or physiologic complications, and that appropriate therapy for the primary disease is provided.

**ADVERSE REACTIONS** HYCOMINE® SYRUP is generally well tolerated. Occasional drowsiness, cardiac palpitation, dizziness, nervousness or gastrointestinal upset may occur.

**HOW SUPPLIED** As an orange-colored, fruit-flavored syrup.

**CAUTION** Federal law prohibits dispensing without prescription.

*Oral prescription where permitted by State Law.*

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Before prescribing **FASTIN**<sup>®</sup> (phentermine HCl), please consult Complete Product Information, a summary of which follows:

**INDICATION:** FASTIN is indicated in the management of exogenous obesity as a short-term (a few weeks) adjunct in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

**CONTRAINDICATIONS:** Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate-to-severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma.

Agitated states.

Patients with a history of drug abuse.

During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

**WARNINGS:** Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued.

FASTIN may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

**Drug Dependence:** FASTIN is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of FASTIN should be kept in mind when evaluating the desirability of including a drug as part of a weight-reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia.

**Usage in Pregnancy:** Safe use in pregnancy has not been established. Use of FASTIN by women who are or who may become pregnant, and those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and infant.

**Usage in Children:** FASTIN is not recommended for use in children under 12 years of age.

**PRECAUTIONS:** Caution is to be exercised in prescribing FASTIN for patients with even mild hypertension.

Insulin requirements in diabetes mellitus may be altered in association with the use of FASTIN and the concomitant dietary regimen.

FASTIN may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

**ADVERSE REACTIONS:** *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure. *Central Nervous System:* Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache, rarely psychotic episodes at recommended doses. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria. *Endocrine:* Impotence, changes in libido.

**DOSAGE AND ADMINISTRATION:** *Exogenous Obesity:* One capsule at approximately 2 hours after breakfast for appetite control. Late evening medication should be avoided because of the possibility of resulting insomnia.

Administration of one capsule (30 mg) daily has been found to be adequate in depression of the appetite for twelve to fourteen hours. FASTIN is not recommended for use in children under 12 years of age.

**OVERDOSAGE:** Manifestations of acute overdosage with phentermine include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension, and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

Management of acute phentermine intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard. Acidification of the urine increases phentermine excretion. Intravenous phenolamine (REGITINE) has been suggested for possible acute, severe hypertension, if this complicates phentermine overdose.

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makes all babies high risk, and we ought to aspire to universal FHR monitoring in order to provide a safer transition for the fetus to the outside world" in Nochimson DJ, Cetrulo CL: Intrapartum fetal monitoring. (*J Fam Pract* 4:845, 1977.)

The idea that all babies are to be considered at high risk is one that needs to be proved so as to justify the technology we are offered as a solution. Dr. Cetrulo has participated in another later study (1976) in which "the electronic fetal monitor is associated with an increased section rate and this without apparent improvement in fetal outcome when compared with an auscultated group."<sup>1</sup> Preliminary results in a recent study at the Beth Israel Hospital in Boston suggest that electronic fetal monitoring is of marginal value in low-risk pregnancies (*Personal Communication from Raymond Neutra, 1977*).

Those of us who view childbirth as a family event rarely requiring medical intervention are dismayed at the uncritical introduction of this technology as a universal remedy.

We recognize that at the time of authorship (1974) the enthusiasm for the monitor may have been unchallenged by critical considerations. Now that this is no longer true, we take The Journal to task for not exercising responsible editorial prerogatives to keep their readers up to date in a rapidly developing field of inquiry.

Stanley E. Sagov, MD  
Richard I. Feinbloom, MD  
Family Practice Group and  
Family Health Care Program  
Harvard Medical School  
Cambridge, Massachusetts

#### Reference

1. Haverkamp AD, Thompson HE, McFee JG, Cetrulo, C: Evaluation of continuous fetal heart rate monitoring in high-risk pregnancy. *Am J Obstet Gynecol* 125:310, 1976

The preceding letters were forwarded to Drs. Nochimson and Cetrulo who respond as follows:

To the Editor:

Thank you very much for forwarding the responses to my recent article (*Intrapartum fetal monitoring, J Fam Pract* 4:845, 1977). I would like to reply to those responses as follows:

Every physician who delivers babies, I am sure, remembers the upper middle-class mother who goes through "normal labor" and then delivers an unexpected stillbirth with no apparent diagnosis. Since the advent of continuous fetal heart rate monitoring in labor, the intrapartum perinatal death rate of monitored babies is virtually zero in many well-respected Ob-Gyn institutions (LAC-USC Medical Center, Columbia Presbyterian Medical Center, and University of Utah College of Medicine). Also, in 50 years of "careful observations" of labor by nurses, the perinatal mortality rate has never come close to our current intrapartum perinatal mortality figure.

In the Colorado survey,<sup>1</sup> trained midwives were used who gave continuous care to the labor patients, and very few people today can afford this type of care. The monitor is less expensive than the cost of training a midwife and in most institutions there are not enough midwives to stay with the laboring patients 100 percent of the time of every labor. Also, 483 patients provide a very small sample when one considers that the perinatal mortality rate is calculated on deaths per 1000 live births.

In 1977, the current obstetrical concept that labor is dangerous to the fetus is still operative. In several studies, Hoebel et al<sup>2</sup> and Sokol et al<sup>3</sup> have shown that approximately 20 percent of patients who are normal or low risk prior to labor became high risk during labor and one cannot predict which of these low-risk patients will become high risk.

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3. Sokol RJ, Rosen MG, Stojkov J, et al: Clinical application of high-risk scoring on an obstetrical service. *Am J Obstet Gynecol* 128:652, 1977

Dr. Cetrulo, an author of this paper and of the Colorado paper, still believes "that every baby in labor is at risk and should undergo routine electronic surveillance during labor."

The incidence of primary cesarean section in many good obstetrical institutions has not increased for the diagnosis of fetal distress (LAC-USC Medical Center, Columbia Presbyterian Medical Center, University of Utah College of Medicine). The overall incidence of primary cesarean sections has increased, but for indications other than fetal distress. For instance, there has been a complete change in attitude toward the care of patients in labor and an increase in the number of high-risk pregnancies.

It costs roughly \$25.00 to monitor a baby during labor and this compares favorably with any other laboratory test performed on the mother. It may cost as much as \$250,000 to take care of one brain damaged individual over a 50-year life span as a result of perinatal asphyxia. Considering all of these points and the minimal expense and inconvenience involved, I am firmly convinced that intrapartum fetal monitoring should be performed on a routine basis and that there is no diagnosis of normal labor and normal delivery except in retrospect.

*David J. Nochimson, MD*  
Director, Maternal-Fetal Medicine  
Baystate Medical Center-Wesson  
Women's Unit  
Associate Clinical Professor  
Tufts University School of Medicine  
Department of Obstetrics-Gynecology  
Springfield and Boston, Massachusetts

### Assessment of Quality of Care

To the Editor:

I would like to join the discussion between Dr. Buttery and Dr. Froom in the Letters to the Editor column of *The Journal* for April 1977 concerning evaluation of quality of care by family physicians.

I agree with Dr. Froom that assessment of quality of care is difficult, but I also think that this is a unique opportunity for a significant contribution by academic Departments of Family Practice.

During the past six months, we have spent some time in adapting criteria for comprehensive evaluation of indicator cases in primary care<sup>1</sup> to a protocol which is both practical and financially feasible for research in a small Department of Family Practice. We are using essential hypertension as the first indicator case since we feel it is an excellent example of a problem with combined opportunities for patient care and research by family physicians.

It is my opinion that this would also be an ideal area for development of cooperative research among several Departments of Family Practice and perhaps a joint grant application to develop a prototype project on comprehensive evaluation of indicator or tracer conditions in primary care residency programs.

We would certainly be interested in hearing from Dr. Buttery or other residency programs who might be interested in cooperating in such a project and grant application. In spite of Dr. Froom's pessimism, I think this can be done.

*James A. Burdette, MD*  
Department of Family Practice  
University of Kentucky  
College of Medicine  
Lexington, Kentucky

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1. Haverkamp AD, Thompson HE, McFee JG, Cetrulo C: The evaluation of continuous fetal heart rate monitoring in high-risk pregnancy. *Am J Obstet Gynecol* 125:310, 1976
2. Hobel CJ, Hyvarinen MA, Okada DM, et al: Prenatal and intrapartum high-risk screening. *Am J Obstet Gynecol* 117:1, 1973

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1. Burdette JA, Babineau RA, Mayo F, et al: Primary medical care evaluation: The AAFP-UNC collaborative study. *JAMA* 230:1668, 1974


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