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.

The Consultation Note

To the Editor:

Family physicians provide the major portion of the primary care for their patients. Studies have shown that family physicians handle 95 to 98 percent of the definitive care for their patients in the office.[1] Similarly, family physicians maintain a large portion of the direct care for their hospitalized patients. In the hospital setting, however, the consultation or referral rate is much higher.[2] The total care of the family cannot be met by any single physician. When more specialized care is needed, the continuum of care naturally extends into the arena of consultation and referral.

The consultation process breaks down when open communication is not maintained. If this occurs, continuity of care is lost, and the patient is the one who ultimately suffers.

A written consultation note or form better defines the patient's problems, workups done, reasons for consultation, and goals of the consultation. This form should improve communication and better delineate the consultant's role in both the patient's outpatient and hospitalized care. A consultation note should therefore be considered one of the key elements in a successful consultation.

The consultation note should include (1) a brief statement of the problem and reason for the consultation, (2) a master problem list to put the present illness into perspective for the consultation, (3) history and physical findings that pertain to the present consultation, (4) laboratory and x-ray findings, current and attempted therapies, (5) specific questions the family physician wants answered, (6) a statement specifying the level of care desired of the consultant, ie, consultation vs referral, and (7) a statement requesting follow-up.

The consultation note is not so radical an idea as it may first appear. Although it requires more time on the part of the family physician to formulate and write, the benefits of providing optimal consultant care for the patient are surely worth it.

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2. Slabaugh RC, Ringiewicz M, Babineau RA: The hospital work at a family practice group in a medium sized community in New England. J Fam Pract 11: 287, 1980

Use of the Family APGAR

To the Editor:

Over the past four years, Smilkstein et al have published several articles[1-3] in the *Journal of Family Practice* concerning the validity and reliability of the Family APGAR questionnaire as a measure of family function. The questionnaire was designed to measure a family member's satisfaction with five empirical components of family function. Since the publication of their first paper in 1978, Smilkstein et al have attempted to validate the instrument by administering it to married university students, adult community mental health patients, college students in an introductory psychology course, adults in a university psychiatric clinic, Taiwanese students aged 10 to 13 years, and last, new patients in a university family medical practice.

I applaud the efforts of Dr. Smilkstein and colleagues. The development of an instrument for the rapid screening of family function is beneficial to both practitioners and researchers interested in family epidemiology and health care utilization. At the Duke University Family Medicine Center, a similar instrument has been developed over the past two years. Different family characteristics have been empirically chosen for our questionnaire based on our reading of the social science and family therapy

literature. I have administered the questionnaire to 154 individuals from 128 separate families. I have not used the same criteria as Smilkstein to validate this instrument, but a comparison of my initial findings with those of Smilkstein serves to highlight problems facing investigators of family function.

The questionnaire consists of 13 questions with the total score ranging from 0 to 100. Equal to or below 62 was empirically defined as a sick or poorly functioning family. Twenty-four percent of the interviewees in my study scored in the poorly functioning category. In two articles recently published in the *Journal*,[4,5] the percentage of patients with psychosocial diagnoses in family practices in Sacramento and Canada ranged from 30.5 to 33.3 percent. By comparison, the distribution of Family APGAR scores achieved by patients in the university family practice showed 15.3 percent scored less than 7 out of a total possible score of 10; these respondents were considered to have moderately to highly dysfunctional families. The authors[3] noted the bunching of responders at high scores and stated that this amplified the worth of the Family APGAR as a screen for patients who perceive their family to be dysfunctional.

At Duke, we have noted that interviewees not uncommonly deny family problems and give socially desirable responses to our family function questionnaire, thereby falsely elevating their scores. It is not clear why the Family APGAR appears to identify a smaller percentage of poorly functioning families in a family practice than in my study or the percentage of persons with psychosocial diagnoses in the Sacramento and Canadian practices. Two explanations are that the comparison is not valid because different facets of a patient's well-being are measured in each study and that the study populations are not comparable.

I am concerned, however, that the Family APGAR questionnaire may be relatively insensitive, leading to falsely labeling sick families as well families. This is important because physicians who are sensitive to family problems may easily identify patients with highly dysfunctional families. But a family function questionnaire, if it is to be valuable, must entice patients who otherwise would discuss with their physician only somatic complaints to reveal dissatisfaction with their family and its functioning. By asking only five broad questions, the Family APGAR may too easily permit a patient to deny family problems.

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1. Smilkstein G: The Family APGAR: A proposal for a family function test and its use by physicians. J Fam Pract 6:1231, 1978

2. DelVecchio Good MJ, Smilkstein G, Good BJ, et al: The Family APGAR index: A study of construct validity. J Fam Pract 8:577, 1979

3. Smilkstein G, Ashworth C, Montano D: Validity and reliability of the Family APGAR as a test of family function. J Fam Pract 15:303, 1982

4. Brennan M, Noce A: A study of patients with psychosocial problems in a family practice. J Fam Pract 13:837, 1981

5. Stumbo D, DelVecchio Good MJ, Good BJ: Diagnostic profile of a family practice clinic: Patients with psychosocial diagnoses. J Fam Pract 14:281, 1982

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

I appreciate the opportunity to respond to Dr. Hoffman's letter in which he questioned the efficacy of the Family APGAR in identifying psychosocial problems. In this connection I would like to make the following comments:

1. The Family APGAR is a screening instrument for family function.

2. One cannot always equate the level of family function with the psychosocial status of the patient. A patient with family dysfunction will almost invariably manifest psychosocial problems; however, patients with psychosocial problems may not have family dysfunction. Psychosocial problems result from stressful life events that are not buffered or modified by a patient's resources (primarily family, friends, and groups). Thus one or more overwhelming stressful life events may cause psychosocial problems even with satisfactory family function.

3. The goal of the Family APGAR questionnaire is to help the physician in assessing whether the family is the source of the patient's psychosocial problem or a resource in time of trouble.

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Alcoholism in Family Practice

To the Editor:

The September 1982 article by C. Richard Kirkwood et al on the 50 most common diagnoses in Pacific Northwest family practices provides a ranked list of these 50 diagnoses (*The diagnostic content of family practice: 50 most common diagnoses recorded in the WAMI community practices. J Fam Pract 15:485, 1982*). I find it distressing, although predictable,

that alcohol (3031) is not even in the top 50, much less in the top five or ten, where it belongs. It is naive to hope that alcoholism is being treated, but not recorded "to protect the patient."

It is equally unfortunate that the authors do not comment on this omission, especially since an American Indian population is included in the survey, a group in which alcoholism rates among men routinely exceed 50 percent.

In our residency training, we stress early assessment and appropriate treatment of alcohol abuse or dependence. We also help physicians, a high-risk population, focus on their own attitudes and drinking.

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Teaching Occupational Medicine

To the Editor:

It was a pleasure to read of the efforts of the Department of Family Medicine at the Medical University of South Carolina to introduce occupational medicine to the family physician *(Hainer BL, Dannenberg AL, Schuman SH: Teaching occupational medicine in a family medicine residency program. J Fam Pract 14:1150, 1982)*. The American Academy of Family Physicians and American Occupational Medical Association have also realized this necessity and established a joint liaison committee in 1979, which has since been joined by the Society of Teachers of Family Medicine.

The committee will, in November 1982, present to its parent organizations a core curriculum on occupational medicine for family practice residency programs. It is also working with the Arizona Center for Occupational Safety and Health in the preparation of modules on occupational health topics, a *Primer on Occupational Health for the Family Physician,* a workshop on teaching how to take an adequate occupational history, and is preparing for a national meeting in September 1983 on occupational health for the family physician.

The committee, among its many other charges, will be more than happy to help set up educational lectures and suggest speakers for the purpose of making family physicians more aware of their active role in occupational medicine and providing them with the information necessary to remain updated in this rapidly changing field. The committee can be reached for further information or making suggestions by contacting its chairman.

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Inappropriate Drug Prescribing

To the Editor:

In a recent editorial *(Geyman JP: Inappropriate drug prescribing: A soluble problem? J Fam Pract 15:15, 1982)*, it was correctly noted that inappropriate drug prescribing, particularly of antibiotic and psychotropic agents, is a continuing problem. This situation has been remarkably persistent through the years despite major educational efforts and repeated verbal and published admonitions.

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Since efforts in the cognitive area have not eliminated the problem, perhaps it is time to consider the affective concomitants of medical practice. What does it feel like to be in an examining room with a patient who pleads for medication to relieve mental discomfort in a setting in which patient loads and economic realities militate against prolonged counseling? What emotions does a physician experience upon learning that a patient diagnosed as having viral bronchitis and treated without antibiotics two days ago has now been admitted to a hospital with a diagnosis of pneumonia by another physician? In an age in which knowledge and certainty are valued highly, how does the physician cope with ambiguity and the necessity of "playing the odds" in the ambulatory treatment of infections, where decisions must often be made on the basis of incomplete information?

There seems to be no reasonable prospect that human emotions, either in patients or physicians, will be completely replaced by rational thinking in the foreseeable future. A program to change physician behavior can succeed only if it is constructed in accordance with this obvious fact.

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and
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Viral Hepatitis

To the Editor:

The otherwise excellent article by Joel Alcoff titled "Viral Hepatitis" in the July 1982 issue contains a substantive error *(J Fam Pract 15: 141, 1982)*. Postexposure prophylaxis against hepatitis A is .02 mL/kg of immune globulin, rather than the .06 mL/kg quoted in the article.[1]

Pre-exposure prophylaxis for up to two or three months is also at the lower dosage level, while the higher dosage level is utilized every five months for prolonged exposure.

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Reference

1. Immunization Practices Advisory Committee: Immune globulins for protection against viral hepatitis. MMWR 34: 426, 1981

To the Editor:

Dr. Alcoff's article on viral hepatitis in the July 1982 issue of *The Journal of Family Practice* provided a good review of the topic.[1] One statement in the article could be somewhat misleading and probably deserves some clarification. When referring to the person who is a chronic carrier of HB_sA_g, the author states that the prognosis for this condition is excellent.

Several recent reports have indicated a markedly increased risk of primary hepatocellular carcinoma in chronic carriers.[2,3] This tumor is a common tumor in Southeast Asians (who also have high rates of the carrier state). Although it is not yet clear if any preventive steps can be taken, a preliminary report from China of an HB_sA_g immune RNA showed some promise.[4]

In the meantime, clinicians who see HB_sA_g carriers, especially Southeast Asians, should be aware of this potential complication.

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1. Alcoff J: Viral hepatitis. J Fam Pract 15:141, 1982
2. Beasley RP, Hwang L, Lin C, et al: Hepatocellular carcinoma and hepatitis B virus. Lancet 2:1129, 1981
3. Viola LA, Coleman JC, Fluken JL, et al: Natural history of liver disease in chronic hepatitis B surface antigen carriers. Lancet 2:1156, 1981
4. Shi-Shan L, Fu-Ying H, Chang-Fu L, et al: Preparation and clinical use of HB_sA_g immune RNA. Lancet 1:197, 1982

Use of Pneumococcal Vaccine

To the Editor:

I am writing in regard to an article that appeared in the December 1982 issue of the *Journal of Family Practice* by H. James Brownlee et al, entitled, "The Utilization of Pneumococcal Vaccine in a Family Practice Residency" *(J Fam Pract 15:1111, 1982).*

I must strongly disagree with the content of the article, particularly in regard to recommendations for the use of pneumococcal vaccine in elderly patients. Although the manufacturers advocate the use of the vaccine for all elderly, the literature does not support this position. In the discussion, the authors do mention a review done by Hirschman and Lipsky, which finds little evidence to support widespread use of the pneumococcal vaccine. The review also shows that there is practically no evidence to support its routine use in an elderly population, since it has never been tested on ambulatory or institutionalized elderly.

The authors draw the conclusion that "until further evidence appears, it seems reasonable to continue to give pneumococcal vaccine to those over 60 years of age." It would be more reasonable to conclude that until further evidence is available, the vaccine should not be used routinely in the elderly because of cost, morbidity, and lack of documented evidence of efficacy. I believe my position would be supported by most people working in the field of aging, and also by most individuals in the area of infectious disease.

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A Reader's Comment

To the Editor:

The Family Practice Grand Rounds, "Unstable Angina and the Intermediate Syndrome" by Richard L. Holve et al *(J Fam Pract 15: 861, 1982),* was a good discussion of a subject area in which medical knowledge is rapidly evolving. However, in *The Journal of Family Practice* I have come to expect more than a good discussion of clinical and technical details. Such discussions can be found in abundance in the *Annals of Internal Medicine,* the *American Heart Journal,* or *The New England Journal of Medicine. The Journal of Family Practice* usually offers a discussion of broader biopsychosocial issues in the care of patients. In the case in question, the inclusion of personal and family considerations in the decision to proceed with surgery would have been more characteristic of your fine journal. From the case report we learned nothing about the patient except that he "was a 64-year-old Mexican-American man with a history of adult-onset diabetes mellitus, hypertension, osteoarthritis, peptic ulcer disease, multiple abdominal and spinal surgeries, and depression." The final paragraph in the article reminds us that "treatment must be selective with regard to the patient and his lifestyle." But we are told nothing about the patient or his lifestyle.

The unique perspective offered by family medicine is gradually contributing to the "rehumanization" of medicine in America. *The Journal of Family Practice* can continue to lead in presenting that perspective if it does not begin to sound like "those other journals."

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Family Practice at UCLA

To the Editor:

I would like to comment on the article by Ivan N. Mensh entitled "Selection and Recruitment of Medical Students for Family Practice" *(J Fam Pract 15:805, 1982).* The UCLA Family Medicine Group appreciates the compilation of statistics regarding UCLA vs University of Washington medical graduates during the decade 1972 to 1981. It was nice to see that the number of UCLA graduates entering family practice approximately tripled during the second half of the decade. During much of this time we were a beleaguered division with only three or four full-time faculty members. Whether you choose to give credit to those faculty for their impact, or cite the strength of family practice as an "idea whose time has come," it would be charitable and accurate to mention that this is a fifth significant variation among the frequencies that were measured.

Given the grand total figures cited in Table 1, it would appear that UCLA graduated an additional 360 medical students during this decade. Thus the UCLA total would represent an approximate 29

percent increase over the number of UW medical students (in contrast to the 44 percent stated in the article). Again, my thanks for providing the tabulation, which demonstrates increasing viability of family medicine at UCLA.

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Ileostomy for Ulcerative Colitis

To the Editor:

It was with great interest that I read the article on ulcerative colitis by Dr. Weigert et al *(J Fam Pract 15:621, 1982)*. With regard to the continent ileostomy (Koch pouch), I think I speak from a great deal of experience. I myself have had this procedure, have had ulcerative colitis, and feel that this procedure is superior to the conventional ileostomy, which I have also had. Certainly, both are an improvement over the symptoms so debilitating to the patient with ulcerative colitis.

I must take issue with Dr. Ram when he states that there is a higher degree of complications with the Koch pouch, and therefore, a standard ileostomy had been recommended to the patient in the article. I lecture to many patients regarding the continent ileostomy, since I serve as a medical advisor to the Los Angeles Chapter of the United Ostomy Association. A conventional ileostomy is no longer the last-resort, unsatisfactory operation of the past because of advances in surgical techniques and in preoperative and postoperative care, as well as improvements in modern external appliances. A continent ileostomy, however, substitutes an unobtrusive gauze pad for a bag filled with liquid intestinal contents. The advantages are obvious. There are few operations that contribute so dramatically to an improved quality of life as a Koch ileostomy.

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Prevalence of Hypothyroidism

To the Editor:

Regarding the article by Peter J. Rizzolo and Paul M. Rischer in the June issue of the *Journal*, entitled "Re-evaluation of Thyroid Hormone Status After Long-Term Hormone Therapy" *(J Fam Pract 14: 1017, 1982)*, I would offer the following comments:

Based on my own private practice experience over the last five and a half years, the quoted prevalence in the index population is hopelessly low. Postulating a total practice population of perhaps 30 percent of the 6,000 cited by the authors, I can come up with more than their two dozen cases of hypothyroidism off the top of my head (certainly a thorough record search on my part would reveal even more) that are, most emphatically, patients diagnosed as hypothyroid by documented increases in thyroid stimulating hormone (TSH). I can only assume that the authors are dealing with a fragmentary and self-selected population, and generalizing from such should be done with extreme caution, not the near bombast that projects such a series into a "$40 million per year saving" on unnecessary medication alone. Perhaps in the university setting the authors are sufficiently insulated from the unwarranted conclusions third-party payers may derive from such statements, but the patients and the majority of the family physicians in this country certainly are not.

Second, any economic benefit truly generated must be balanced against the cost of the additional screening, not against a vacuum. What are the anticipated costs of three complete thyroid panels per patient plus professional time devoted to analysis of symptom scores and physical findings? Again, in my own practice, these figures would be $\$48 \times 3 + \$18 \times 3$, or $198 per patient, which would buy a lot of replacement thyroid medication. I am not suggesting that persons be treated on shaky diagnostic grounds; I am merely suggesting that this paper offers no useful information, medical or economic, on rescreening the bulk of patients carrying a diagnosis of hypothyroidism in a general family practice setting. It could be construed to offer such guidelines to the reimburser, *Physicians Desk Reference* in hand, who sees such conclusions as presented combined with such statements as (replacement thyroid medication) "is not without side effects." Whoever implied that it *was*?

Finally, the well-recognized connection between recurrent bouts of thyroiditis and ultimate development of permanent hypothyroidism leaves me wondering for what we are sparing these "unnecessarily medicated" people: a future truly free of hypothyroidism off treatment, or an eventual recurrence of that thyroid failure for which they were once perhaps quite appropriately treated?

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