

**Valium® (diazepam/Roche)®**  
**Before prescribing, please consult complete product information, a summary of which follows:**

The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other anti-depressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect.

**Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**How Supplied:** For oral administration, round, scored tablets with a cut out "V" design—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10. Tel-E-Dose® packages of 100, available in boxes of 4 reverse-numbered cards of 25, and in boxes containing 10 strips of 10.

Imprint on tablets:  
2 mg—2 VALIUM® (front)  
ROCHE (scored side)



5 mg—5 VALIUM® (front)  
ROCHE (scored side)

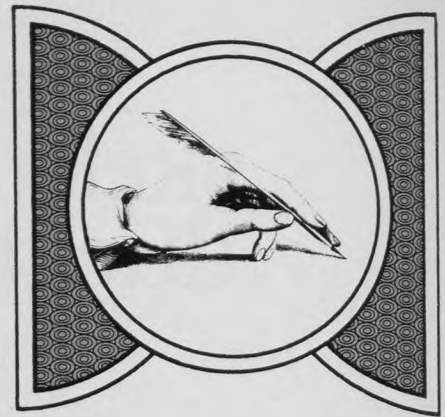


10 mg—10 VALIUM® (front)  
ROCHE (scored side)



**ROCHE**® ROCHE PRODUCTS INC.  
Manati, Puerto Rico 00701

# 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 Family and Family Medicine

To the Editor:

The article by Merkel (*Merkel WT: The family and family medicine: Should this marriage be saved? J Fam Pract 17:857, 1983*), expressing his opinion that family-based medical care is undesirable and/or impossible, deserves additional comment to that of Ramsey,<sup>1</sup> so as to highlight Merkel's poorly developed and inaccurate conclusions.

As noted by Ramsey, Merkel seems to build most of his arguments against family-based medical care on professional role ("turf") conflicts. Merkel seems not to realize that he is defending a piece of ground that is not wanted by family physicians. His arguments regarding logistical, conceptual, and educational barriers to family physicians becoming family therapists are analogous to those of a cardiovascular surgeon explaining why family physicians cannot perform mitral valve replacements. The objections are valid, but trivial. Family physicians do not wish to become family therapists; as described elegantly by Doherty and Baird,<sup>2</sup> family physicians merely wish to borrow a limited, but powerful, repertoire of group communication skills. As noted by Huygen,<sup>3</sup> Comley,<sup>4</sup> and Minuchin et al.,<sup>5</sup> as little as two or three hours invested in clarifying family members' needs and expectations can pay truly remarkable

dividends in the health of the identified patient.

Merkel misses the point in several other assertions. For example, he describes ethical barriers to caring for the family as a whole. This is another trivial argument because family physicians are not interested in caring for the family as a whole. Ransom<sup>6</sup> and Schwenk and Hughes<sup>7</sup> have clearly described both the undesirability and the impossibility of doing so for a variety of reasons in addition to ethical ones. As another example, Merkel describes the value of nonlinear, interactional systems thinking, then seems to castigate the field of family studies because its useful research and clinical work comes from a somewhat loose and complex system of unrelated disciplines. Finally, Merkel concludes that family physicians cannot provide family-based care because (1) it is too hard, (2) it evokes too much personal anxiety in the physician, and (3) it will cause disparaging remarks to be made by medical colleagues. These objections are not only spurious, but somewhat demeaning to a specialty whose members have shown considerable success in managing complexity, ambiguity, intimacy, and professional disenfranchisement.

The simple truth is that family physicians can and should provide family-based care because the family is both a source of diagnostic data and a medium for therapeutic intervention that makes for more

effective and efficient care of the individual patient. Further research is needed not to prove this truth, but rather to make future family-based medical care that much more successful.

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6. Ransom DC: Random notes: The family as patient—What does this mean? *Fam Syst Med* 1:99, 1983
7. Schwenk TL, Hughes CC: The family as patient in family medicine: Rhetoric or reality? *Soc Sci Med* 17:1, 1983

To the Editor:

We very much enjoyed reading the provocative and well-written article by Dr. William Merkel in the November issue of the *Journal* titled: "The Family and Family Medicine: Should This Marriage Be Saved?" (*J Fam Pract* 17:857, 1983). We agree that teaching residents about the family is a difficult task for medical and behavioral faculty alike. We also agree that further research is needed to document how a family orientation is beneficial to patients.

We do not agree, however, with the contention that the marriage of

family medicine and family systems theory is ill-advised. In fact, it is a fundamental error in logic that presumes that there is a marriage at all. That family medicine is a distinct field of medicine that draws heavily on other fields is a well-worn cliché. Family systems is just another one of those other fields, albeit a very important one.

We believe that the family vs individual approach to family medicine need not be an either-or problem. It is the conception of how change occurs that is the distinguishing feature of a family approach rather than the method or techniques of intervention used. For family practice physicians the attitudinal shift from an individual to a family focus simply means that the family physician treats the patient within his or her social context. The family is an important part of that context.

The author contends that the founding fathers used the "family concept" primarily for political means to distinguish the "new breed" from the "old school" general practitioner. It seems ironic that these same founding fathers distinguish family practice from general practice primarily on the strength of the behavioral training they receive while in residency, even though none has suggested that it is reasonable to train residents to become family therapists. The need is not to train them in family therapy, but to encourage and model a conceptual shift from conventional medical training to an appreciation of the circular causality to which the author refers. A fundamental appreciation of the biopsychosocial model, an understanding of the relationship of stress and illness, and an appreciation of the impact of family and other support systems on health

must all be a part of this process.

We strongly believe that it is advantageous and not necessarily a distortion to think "family" whether or not the family is simultaneously present. Even if "the system" is never fully conceptualized, the benefits of this approach keep the physician focused on the patient in his world rather than the patient that appears in his medical record; further, it increases the likelihood that the physician will be more attuned to the patient's concerns and more successful in building a successful relationship. While it is occasionally necessary to convene the family either for further assessment or for family therapy, it is not a common happening, nor should it be. It should simply be present in the family physician's armamentarium.

The author contends that behavioral scientists are the most likely people to bridge the "family" gap in programs. We doubt it! It has been our experience that the most effective way of bridging the gap is to present effective residency-trained family physician faculty role models who have witnessed the benefits of the "family approach" firsthand. The role of the behavioral scientist is to teach the fundamental skills necessary to do the job the faculty should be modeling.

As to Dr. Merkel's observation that family medicine will be out of step if it succeeds in practicing good behavioral medicine, most of us would proudly point out that family medicine has always been viewed as being out of step with traditional medicine, largely because of its commitment to the practice of family-oriented behavioral medicine.

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# Wytensin<sup>®</sup> (guanabenz acetate)

## 4 mg b.i.d.

### Brief Summary

Before prescribing, consult the complete package circular.

**Indications and Usage:** Treatment of hypertension, alone or in combination with a thiazide diuretic.

**Contraindication:** Known sensitivity to the drug.

**Precautions:** 1. Sedation: Causes sedation or drowsiness in a large fraction of patients. When used with centrally active depressants, e.g., phenothiazines, barbiturates and benzodiazepines, consider potential for additive sedative effects. 2. Patients with vascular insufficiency: Like other antihypertensives use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease, or severe hepatic or renal failure. 3. Rebound: Sudden cessation of therapy with central alpha agonists like Wytensin may rarely result in "overshoot" hypertension and more commonly produces increase in serum catecholamines and subjective symptomatology.

**INFORMATION FOR PATIENTS:** Advise patients on Wytensin to exercise caution when operating dangerous machinery or motor vehicles until it is determined they do not become drowsy or dizzy. Warn patients that tolerance for alcohol and other CNS depressants may be diminished. Advise patients not to discontinue therapy abruptly.

**LAB TESTS:** In clinical trials, no clinically significant lab test abnormalities were identified during acute or chronic therapy. Tests included CBC, urinalysis, electrolytes, SGOT, bilirubin, alkaline phosphatase, uric acid, BUN, creatinine, glucose, calcium, phosphorus, total protein, and Coombs' test. During long-term use there was small decrease in serum cholesterol and total triglycerides without change in high-density lipoprotein fraction. In rare instances occasional nonprogressive increase in liver enzymes was observed, but no clinical evidence of hepatic disease.

**DRUG INTERACTIONS:** Wytensin was not demonstrated to cause drug interactions when given with other drugs, e.g., digitalis, diuretics, analgesics, anxiolytics, and antiinflammatory or antineoplastic agents, in clinical trials. However, potential for increased sedation when given concomitantly with CNS depressants should be noted.

**DRUG/LAB TEST INTERACTIONS:** No lab test abnormalities were identified with Wytensin use.

**CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY:** No evidence of carcinogenic potential emerged in rats during a two-year oral study with Wytensin at up to 9.5 mg/kg/day, i.e., about 10 times maximum recommended human dose. In the *Salmonella* microsome mutagenicity (Ames) test system, Wytensin at 200-500 mcg per plate or at 30-50 mcg/ml in suspension gave dose-related increases in number of mutants in (TA 1537) of five *Salmonella typhimurium* strains with or without inclusion of rat liver microsomes. No mutagenic activity was seen at doses up to those which inhibit growth in the eukaryotic microorganism, *Schizosaccharomyces pombe*, or in Chinese hamster ovary cells at doses up to those lethal to the cells in culture.

In another eukaryotic system, *Saccharomyces cerevisiae*, Wytensin produced no activity in an assay measuring induction of repairable DNA damage. Reproductive studies showed a decreased pregnancy rate in rats given high oral doses (9.6 mg/kg), suggesting impairment of fertility. Fertility of treated males (9.6 mg/kg) may also have been affected, as suggested by decreased pregnancy rate of mates, even though females received drug only during last third of pregnancy.

**PREGNANCY:** Pregnancy Category C. WYTENSIN MAY HAVE ADVERSE EFFECTS ON FETUS WHEN ADMINISTERED TO PREGNANT WOMEN. A teratology study in mice indicated possible increase in skeletal abnormalities when Wytensin is given orally at doses 3 to 6 times maximum recommended human dose of 1.0 mg/kg. These abnormalities, principally costal and vertebral, were not noted in similar studies in rats and rabbits. However, increased fetal loss has been observed after oral Wytensin given to pregnant rats (14 mg/kg) and rabbits (20 mg/kg). Reproductive studies in rats have shown slightly decreased live-birth-indices, decreased fetal survival rate, and decreased pup body weight at oral doses of 6.4 and 9.6 mg/kg. There are no adequate, well-controlled studies in pregnant women. Wytensin should be used during pregnancy only if potential benefit justifies potential risk to fetus.

**NURSING MOTHERS:** Because no information is available on Wytensin excretion in human milk, it should not be given to nursing mothers.

**PEDIATRIC USE:** Safety and effectiveness in children less than 12 years of age have not been demonstrated, use in this age group cannot be recommended.

**Adverse Reactions:** Incidence of adverse effects was ascertained from controlled clinical studies in U.S. and is based on data from 859 patients on Wytensin for up to 3 years. There is some evidence that side effects are dose-related. Following table shows incidence of adverse effects in at least 5% of patients in study comparing Wytensin to placebo, at starting dose of 8 mg b.i.d.

Adverse Effect	Placebo (%) n = 102	Wytensin (%) n = 109
Dry mouth	7	28
Drowsiness or sedation	12	39
Dizziness	7	17
Weakness	7	10
Headache	6	5

In other controlled clinical trials at starting dose of 16 mg/day in 476 patients, incidence of dry mouth was slightly higher (38%) and dizziness was slightly lower (12%), but incidence of most frequent adverse effects was similar to placebo-controlled trial. Although these side effects were not serious, they led to discontinuation of treatment about 15% of the time. In more recent studies using an initial dose of 8 mg/day in 274 patients, incidence of drowsiness or sedation was lower, about 20%. Other adverse effects reported during clinical trials but not clearly distinguishable from placebo effects and occurring with frequency of 3% or less: Cardiovascular—chest pain, edema, arrhythmias, palpitations. Gastrointestinal—nausea, epigastric pain, diarrhea, vomiting, constipation, abdominal discomfort. Central nervous system—anxiety, ataxia, depression, sleep disturbances. ENT disorders—nasal congestion. Eye disorders—blurring of vision. Musculoskeletal—aches in extremities, muscle aches. Respiratory—dyspnea. Dermatologic—rash, pruritus. Urogenital—urinary frequency, disturbances of sexual function. Other—gynecostasia, taste disorders.

**Drug Abuse and Dependence:** No dependence or abuse has been reported.

**Overdosage:** Accidental ingestion caused hypotension, somnolence, lethargy, irritability, miosis, and bradycardia in two children aged one and three years. Gastric lavage and pressor substances, fluids, and oral activated charcoal resulted in complete and uneventful recovery within 12 hours in both. Since experience with accidental overdosage is limited, suggested treatment is mainly supportive while drug is being eliminated and until patient is no longer symptomatic. Vital signs and fluid balance should be carefully monitored. Adequate airway should be maintained and, if indicated, assisted respiration instituted. No data are available on Wytensin dialyzability.

**Dosage and Administration:** Individualized dosage. A starting dose of 4 mg b.i.d. is recommended, whether used alone or with a thiazide diuretic. Dosage may be increased in increments of 4 to 8 mg/day every one to two weeks, depending on response. Maximum dose studied has been 32 mg b.i.d., but doses this high are rarely needed.

**How Supplied:** Wytensin Tablets, 4 mg and 8 mg, bottles of 100.

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## LETTERS TO THE EDITOR

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Finally, we would emphasize that the kind of challenge Dr. Merkel presents is necessary and healthy for the continuing development of our field. It would have been especially timely six or eight years ago, but we must continue to examine the validity of the fundamental principles we are espousing—and, in our opinion, they are holding up rather well!

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To the Editor:

The article by Dr. Merkel (*Merkel WT: The family and family medicine: Should this marriage be saved? J Fam Pract 17:857, 1983*) is both excellent and timely. For many of us who completed our postgraduate training in the early 1970s, when the theorists of family practice seemed to outnumber the clinical teachers of that subject, philosophical arguments about family practice vs general practice seemed only to obscure the real crisis in postgraduate education in family practice, that is, increased competition for patients with concomitantly expanding postgraduate programs in internal medicine, pediatrics, and obstetrics-gynecology. As clinical opportunities accordingly diminished, the tendency was for the more behaviorally oriented members of our faculties to fill up that slack time in our schedules with still more of that ill-digested "family content" to which Dr. Merkel so courageously refers. Whatever subtle benefits such ex-

periences conferred on us must be balanced against the disadvantaged position we were placed in upon applying for hospital privileges, credentials committees being, rightly or wrongly, more interested in the hard data of biomedical training and experience than in the extent of exposure to family theory.

Believing in family-centered primary care, I also believe that such care is best served by a sound education in broad areas of medicine and surgery. To cling, instead, to an ill-advised emphasis on family therapy no longer serves even a political purpose.

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Patients Seeking Family Care  
To the Editor:

In the October 1983 issue of the *Journal* (Wall EM, Shear CL: *Characteristics of patients seeking family-oriented care. J Fam Pract 17:665, 1983*), Wall and Shear report that patients who were divorced were more likely to seek family-oriented health care than were single or married patients. Two possible reasons for this finding are presented by the authors, but at least one other should be considered. Apparently one-person households were not excluded from the analyses. Since divorced persons are more likely than married persons to live alone, they are, for this reason alone, more likely to live in households in which all members seek health care from the same practice. Hence, the finding that divorced persons are more likely to seek family-oriented care may be a statistical artifact.

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