

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.

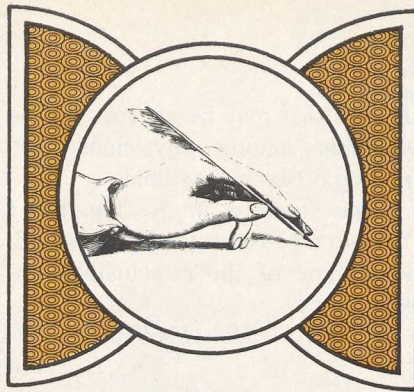
Research in Family Medicine

To the Editor:

Last year Geyman and Berg¹ published an analysis of ten years of publication in *The Journal of Family Practice*. These observations defined the evolution of the research status in the specialty of family medicine, making it clear that the specialty is busy describing its activities. In September of 1984 at the advanced Forum of Family Medicine convened by Gayle Stevens, MD, (Keystone, Colorado), a statement was made that practitioners are not reading family medicine research papers and, therefore, our research is not making an impact to change medical practice.

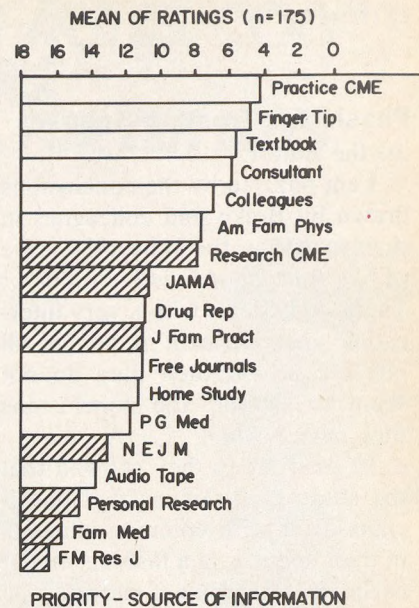
To test this hypothesis and to gather ideas for a keynote speech to the Third Annual Research Day of the Ohio Academy of Family Physicians, I surveyed a one-third sample of the active membership of the Ohio Academy of Family Physicians. There was a 44 percent response to the 396 questionnaires distributed. These questionnaires asked the respondents to prioritize sources of information used to change their practice habits. They were also asked what were the latest two changes they have made, where did they get the information for these specific changes, and did they do research in their practice. If the answer to the latter was in the affirmative, the subjects of their research efforts were solicited.

It was found that 38.6 percent do investigations in their practice. It is



clear that family practice is a curious and action-based specialty. It was disappointing to learn that the results of many of these investigations are not widely reported, though they are shared verbally with their colleagues. It was clear that hallway exchanges, consultations, and other forms of individual contacts were highly valued. There was a suggestion that solo practice may be more professionally isolating than is generally perceived. Solo physicians seem the only ones who favor to any degree the use of home study modules and audio and videotape courses. They also were more dependent upon sales representatives for drug information. Those without library resources and those who had not had the experience of doing literature searches also tended to depend on sales representatives for reprint information. That changes in practice management designed to enhance survival seemed more prevalent than changes in actual medical practice would seem to support the idea that the subjects of this survey, at least, are very responsive to political and system changes.

Figure 1 indicates the prioritization of the sources selected for study. The large bars (low numbers) are those assigned the highest priority. Practice-oriented continuing medical education ranks first even though we continue to preach that nobody learns from lectures. The hatched bars are those consid-



ered to be primarily involved in the presentation of research-oriented information. One might propose several reasons for the comparatively low ranking. Do family physicians trust only the tried and true? Does the litigious nature of our society discourage the introduction of new ideas into practice?

I liberally interpreted the data to indicate that the suggestion at Keystone was true—at least published family medicine research seems to have little impact currently. We might take a lesson from our colleagues in other specialties and spread the gospel of new ideas developed in research in continuing education courses and in those journals that are valued for their CME content. We have been so involved in describing our specialty that little time or thought has been given to what may be an important next step in our evolution.

Tennyson Williams, MD
Professor and Chairman
Department of Family Medicine
The Ohio State University
Columbus

Reference

1. Geyman JP, Berg AO: The Journal of Family Practice 1974-1983: Analysis of evolving literature base. *J Fam Pract* 1984; 18:47-51

Physicians Treating Spouses

To the Editor:

I am puzzled by the conclusions drawn by Boiko and colleagues in their article in the June 1984 issue of *The Journal of Family Practice*.¹ Their study deals with a very interesting and pertinent issue for all physicians, but their data do not seem to support the conclusions they have made.

In their study they showed that the study group of married physicians dealt with common ailments in their spouses in a fashion similar to the control group of married lawyers. Physicians tended to obtain a more complete history and to perform a physical examination more often than did lawyers. Lawyers gave their spouses legal advice more often than did physicians.

Among their conclusions, however, one finds the following statements: "It is concluded that . . . the decision to treat by the physician may compromise good care for his or her spouse." (in the abstract) and "The study demonstrated that . . . there are unique and complex pressures surrounding the physician's decision to treat a spouse."

These conclusions are not documented, and must be considered editorial comments based on other data or presuppositions.

They furthermore discuss a number of factors about physicians' decisions to treat or not to treat a spouse, such as denial, an inability to provide adequate emotional support for a spouse, spouse ingratitude, fear of errors, a "quest for omnipotence," and a lack of objectivity. Their study, however, dealt with none of these factors, and in fact demonstrated that there were only minor differences between physicians and other professionals in the way they handle ailments in their spouses, implying whatever

factors that may be at work are no different among physicians than among other professionals.

The study is interesting, but I believe the discussion is misguided, and some of the conclusions unwarranted.

Douglas Trotter, MD
PHS Hospital
Bethel, Arkansas

Reference

1. Boiko P, Schuman S, Rust P: Physicians treating their own spouses: Relationship of physicians to their own family's health care. *J Fam Pract* 1984; 18: 891-896

The preceding letter was referred to Drs. Schuman, Boiko, and Rust, who respond as follows:

As an alert and motivated reader, Dr. Trotter correctly insists on separation of our study's limited results from the discussion section of the paper. However, after careful rereading of the paper, we cannot agree that the discussion is "misguided"—it is relevant, it is provocative, and it guides the reader to the pertinent literature. If Dr. Trotter wishes to disagree with the conclusions, he should marshal his own study and make a case for his viewpoint, which we hope will be confined to the discussion section of his paper.

Stanley H. Schuman, MD
Patricia E. Boiko, MD
Philip F. Rust, MD
Department of Family Medicine
Medical University of
South Carolina
Charleston

TRINSICON[®] Capsules

HEMATINIC CONCENTRATE
WITH INTRINSIC FACTOR/GLAXO

Brief Summary of Prescribing Information

DESCRIPTION

Each capsule contains—
Special Liver-Stomach Concentrate,
(containing Intrinsic Factor) 240 mg
Vitamin B₁₂ (Activity Equivalent) 15 mcg
Iron, Elemental (as Ferrous Fumarate) 110 mg
Ascorbic Acid (Vitamin C) 75 mg
Folic Acid 0.5 mg
with other factors of Vitamin B Complex present in the
Liver-Stomach Concentrate.

Usual dosage: One Trinsicon Capsule twice a day.

INDICATIONS AND USAGE

Trinsicon[®] (hematinic concentrate with intrinsic factor) is a multifactor preparation effective in the treatment of anemias that respond to oral hematinics, including pernicious anemia and other megaloblastic anemias and also iron-deficiency anemia. Therapeutic quantities of hemopoietic factors that are known to be important are present in the recommended daily dose.

CONTRAINDICATIONS

Hemochromatosis and hemosiderosis are contraindications to iron therapy.

PRECAUTIONS

General Precautions—Anemia is a manifestation that requires appropriate investigation to determine its cause or causes.

Folic acid *alone* is unwarranted in the treatment of pure vitamin B₁₂ deficiency states, such as pernicious anemia. Folic acid may obscure pernicious anemia in that the blood picture may revert to normal while neurological manifestations remain progressive.

As with all preparations containing intrinsic factor, resistance may develop in some cases of pernicious anemia to the potentiation of absorption of physiologic doses of vitamin B₁₂. If resistance occurs, parenteral therapy, or oral therapy with so-called massive doses of vitamin B₁₂, may be necessary for adequate treatment of the patient. No single regimen fits all cases, and the status of the patient observed in follow-up is the final criterion for adequacy of therapy. Periodic clinical and laboratory studies are considered essential and are recommended.

Usage in Pregnancy—*Pregnancy Category C*—Animal reproduction studies have not been conducted with Trinsicon. It is also not known whether Trinsicon can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Trinsicon should be given to a pregnant woman only if clearly needed.

Nursing Mothers—It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when Trinsicon is administered to a nursing woman.

Usage in Children—Safety and effectiveness in children below the age of 10 have not been established.

ADVERSE REACTIONS

Rarely, iron in therapeutic doses produces gastrointestinal reactions, such as diarrhea or constipation. Reducing the dose and administering it with meals will minimize these effects in the iron-sensitive patient.

In extremely rare instances, skin rash suggesting allergy has been noted following the oral administration of liver-stomach material. Allergic sensitization has been reported following both oral and parenteral administration of folic acid.

OVERDOSAGE

Symptoms—Those of iron intoxication, which may include pallor and cyanosis, vomiting, hematemesis, diarrhea, melena, shock, drowsiness, and coma.

Treatment—For specific therapy, exchange transfusion and chelating agents. For general management, gastric and rectal lavage with sodium bicarbonate solution or milk, administration of intravenous fluids and electrolytes, and use of oxygen.

HOW SUPPLIED

Capsules, dark pink and dark red (No. 2). Bottles of 60 (NDC 0173-0364-22), bottles of 500 (NDC 0173-0364-24), and Unit Dose Packs of 100 capsules (NDC 0173-0364-27).

Literature Revised October, 1983.

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