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.

PARADIGMS AND FAMILY MEDICINE

To the Editor:

In response to recently published editorials on paradigms in family medicine (*Ruane T: Paradigms lost: A central dilemma for academic family practice. J Fam Pract 1988; 27: 133–135;* and *Phillips T: Disciplines, specialties, and paradigms. J Fam Pract 1988; 27:139–141*), I agree that we do not need a new paradigm for family medicine. That does not mean, however, that our discipline is without a paradigm. Indeed, the paradigms of family medicine are essential to all areas of medicine, and we all draw from them. As an applied science, the work we do is far removed from the true paradigms found in basic sciences. The scientific work in various medical specialties, however, is part of what Kuhn[1] might call "normal science" based on paradigms central to physics, chemistry, and biology. These paradigms must be elaborated on as they apply to specific disciplines in medicine.

Some of the new philosophers of science have argued that science is a social, rather than purely rational, phenomenon that does not depend on paradigms in the manner Kuhn described. Feyerabend[2] used historical examples to demonstrate that in some instances scientific progress occurred because scientists acted in an irrational manner and that, in fact, rational behavior would have impeded scientific progress. Thus, according to Feyerabend, rationality and scientific success are incompatible.

Munévar[3,4] attempted to reconcile rationality with scientific success by arguing that science is a rational phenomenon only in a social sense and despite the irrationality of individual scientists. The rationally organized science then is one that permits progress to occur despite possible internal inconsistencies. Likewise, the discipline of family medicine, as well as any other medical specialty, can be a rational one even in the absence of a unifying paradigm as long as progress is made in providing quality patient care.

Michael Hagley, MD
Family Practice Residency Program
Barberton Citizens Hospital
Barberton, Ohio

References

1. Kuhn TS: The Structure of Scientific Revolutions, ed 2, enlarged. Chicago, The University of Chicago Press, 1970
2. Feyerabend P: Against Method. London, New Left Books, 1975
3. Munévar G: Radical Knowledge. Indianapolis, Hackett, 1981
4. Munévar G: Toward a social conception of scientific rationality. Trans Nebr Acad Sci 1982; 10:91–95

FETAL HEART VARIABILITY AND FETAL WELL-BEING

To the Editor:

I would like to congratulate Morton Glasser on his excellent review of "Strategies to Avoid Unnecessary Cesarean Section" (*J Fam Pract 1988; 27:514–518*). Clearly, the answer to the dilemma of accurate predictability of fetal well-being is not simple.

At the same time, I would like to draw attention to a confusing statement in the abstract that does not seem to reflect accurately the material presented in the article itself. Dr. Glasser states in the abstract that maintenance of variability is a better predictor of absence of acidosis than is fetal scalp pH. The text of the article correctly describes the conclusion of Parer[1] that fetal heart variability is a more important predictor of fetal well-being than is blood pH. The blood pH is obviously the "gold standard" for the presence or absences of acidosis, in spite of its lack of better correlation with severely depressed fetuses and low one-minute Apgar scores.[2]

I hope that by drawing attention to this point, the casual reader will be less likely either to discount the article entirely or be misled regarding the utility of fetal scalp pH determination.

William L. Toffler, MD
Assistant Professor of
Family Medicine
Oregon Health Sciences University
Portland

References

1. Parer JT: In defense of FHR monitoring specificity. Contemp Ob/GYN 1982; 18: 228–236
2. Sykes GS, Johnson P, Ashworth F, et al: The Apgar scores indicate asphyxia? Lancet 1982; 1:494–496

SIGMOIDOSCOPY BY FAMILY PHYSICIANS

To the Editor:

The recent publication by Buckley et al (*Buckley RL, Smith MU, Katner HP: Use of rigid and flexible sigmoidoscopy by family physicians in the United States, J Fam Pract 1988; 27:197–200*) was an important con-

continued on page 266

continued from page 254

tribution to the description of diagnostic lower gastrointestinal endoscopy by family physicians. A previously published study lends external confirmation to the sigmoidoscopic frequencies these authors reported. Primary care physicians (n = 94), responding to follow-up after continuing medical education (CME) in flexible sigmoidoscopy, reported procedural frequencies that increased from 2.8 procedures per month to 9.6 procedures per month. Note that the latter figure (ie, 9.6) designates a flexible sigmoidoscopy frequency quite similar to that reported by Buckley et al (7.9 procedures per month).

This study also noted that the frequency of flexible sigmoidoscopy before CME was significantly lower than that of the post-CME rate. This describes another dimension of the lower frequency of rigid sigmoidoscopy when compared with flexible sigmoidoscopy.[1] This finding is congruent with results reported by Buckley et al.

Note that in our study[1] we randomly selected a comparison group from physicians in southern California. Although the date of our study was approximately 18 months earlier than the study of Buckley, we also found that approximately 33 percent of randomly selected primary care physicians were using flexible sigmoidoscopy, a finding similar to that reported by Buckley.

During my preparation for an affirmative support of screening flexible sigmoidoscopy,[2] I polled manufacturers of flexible sigmoidoscopes in the United States to determine how many units they were selling per year. Manufacturers described a primary care market that placed at least 5,000 to 6,000 units per year through the years 1984–1987. This finding suggests that the use of flexible sigmoidoscopy is expanding among primary care physicians. In response to this and other data, the American Academy of Family Physicians and the American Society for Gastrointestinal Endoscopy[3] expanded the scope of this previously published training program to include internists.

Regarding the use of 35- or 65-cm endoscopes, let me point out that all follow-up data suggest that family physicians select the longer sigmoidoscope by a ratio of four-to-one. This decision seems to be wise given the recently published data by Hocutt et al, where the detection rate for cancer was significantly increased by use of the 65-cm sigmoidoscope when compared with the 35-cm sigmoidoscope.[4] This is consistent with preliminary data we published in 1984, where approximately 26 percent of the significant pathologic lesions were detected beyond an insertion depth of 35 cm.[5]

In summary, there is external validation for a 30 to 33 percent prevalence rate of flexible sigmoidoscopy skill among primary care physicians during the period 1984–1986. The availability of flexible sigmoidoscopy appears to have increased utilization among family physicians, which I believe is due to increased acceptance and increased diagnostic power.[6] Let me also suggest that this situation is dynamic with an ever-increasing number of physicians purchasing and utilizing these instruments. In 1989, the prevalence rate of flexible sigmoidoscopy and colonoscopy skills among family physicians will be somewhere between 50 and 60 percent. For the sixth straight year, the flexible sigmoidoscopy and colonoscopy skills course at the American Academy of Family Physicians Scientific Assembly has been completely sold out with a total registration of 200 physicians each year. Many other courses continue to fill with physicians updating their endoscopy skills.

Wm. MacMillan Rodney, MD
Department of Family Medicine
University of California, Irvine

References

1. Rodney WM, Ruggerio C: Outcomes following continuing medical education on flexible sigmoidoscopy. Fam Pract 1987; 4:306–310
2. Rodney WM: Screening flexible sigmoidoscopy: Is it worthwhile? An affirmative view. J Fam Pract 1987; 25:601–607
3. Rodney WM, Felmar E, Auslander M: AAFP-ASGE conjoint course on family practice research. Fam Pract Res J 1986; 5:209–215
4. Hocutt JE, Hainer BL, Jackson MG: Flexible fiberoptic sigmoidoscopy: Its use in family medicine. J Am Board Fam Pract 1988; 1(3):189–193
5. Johnson RA, Quan M, Rodney WM: Continued assessment of flexible sigmoidoscopy in a family practice residency. J Fam Pract 1984; 18:723–727
6. Rodney WM, Beaber RJ, Johnson RA, Quan M: Physician compliance with colorectal cancer screening (1978–1983): The impact of flexible sigmoidoscopy. J Fam Pract 1985; 20:265–269

OBSTETRIC RISK ASSESSMENT

To the Editor:

Dr. Wall has written a timely review of obstetric risk assessment.[1] Indeed, this aspect of prenatal and intrapartum care has become increasingly important as this country finally attempts to address its own poor obstetric record. In Dr. Wall's own state of Oregon, funds for transplants have been diverted to prenatal care.[2] Recent SOBRA legislation will increase the availability of prenatal care nationally. This "boom" in prenatal care will result in a boom in risk-scoring systems. In Utah, for example, the use of state funds targeted for perinatal care is tied to the use of a specific risking system.

In addition to Dr. Wall's criticisms about "risking technology," I would like to add my own concerns. Many of the important studies of risking systems are just plain out of date. A review of Dr. Wall's bibliography reveals that 30 of 43 references were published before 1980; these early studies include the oft-quoted work of Goodwin (1969) and Hobel (1973), who set the standards for much of the subsequent research. Newer technol-

continued on page 328

continued from page 266

ogies of prenatal diagnosis and the recent development of such "screening" tests as α-fetoprotein are not included in these systems.

There have been virtually no studies on the application of these risk scores to the clinical setting. Since most of these scores were developed at high-risk urban medical centers, their applicability to the low-risk, rural family practice setting is suspect. The most glaring example of this weakness is the use of intrapartum scoring[3]; when one of Dr. Hobel's patients is found to be too risky for the birthing room, she is moved next door to the intensive perinatal unit; when a woman in labor in Basin, Wyoming, "risks out," her family physician must call the helicopter, which often arrives, not with the maternal, but with the newborn transport unit. Regionalization of perinatal care, which has benefited from risk-score–motivated referrals, has led to little improvement in obstetric outcome.[4,5] Current risking systems do little to facilitate timely referral of prenatal patients, who later have poor outcomes.

Finally, "lack of prenatal care," as Dr. Wall indicates, has become the whipping boy of obstetrics. Indeed, women who deliver small babies at 32 weeks frequently have fewer prenatal visits than women who deliver normal-sized babies at 40 weeks; that, however, is common sense and not scientific deduction. What few researchers will question, unfortunately, is whether it is the lack of *access* to perinatal care that is causing women to have poor outcomes.

With these concerns in mind, our family practice group, which now deliver over 400 babies a year, examined the record of our own prenatal risking system in predicting poor maternal outcome.[6] The risking system we used was developed by a city-wide committee and has been used extensively in this area. Specific studies on this system are totally lacking. In a comprehensive chart review of 309 prenatal patients, obstetric outcome was stratified into four groups, from good to poor. Spearman correlation coefficient for risk score and outcome was 0.042. A closer correlation was found after certain risk factors were eliminated. Low socioeconomic status, considered a risk factor in almost all studies, was found to be significantly (P = .003) associated with better rather than worse outcome. Our system was poorly predictive of obstetric outcome.

As Dr. Scherger indicates in his commentary, current risking systems are vitally important to the family physician, if only for their dreaded medicolegal implications.[7] I would add that in Utah, the medicolegal tail is wagging the family practice dog. The Utah Medical Insurance Association, which insures the majority of Utah family physicians, has published a set of referral "guidelines" for family physicians practicing obstetrics. I suspect that these guidelines have far greater impact on referral patterns than any risking systems currently in use.

What are needed are critical introspective studies on the application of risking systems to the family practice setting. While most of us lack the resources to pursue large studies, we all can perform "microstudies" on our own practices. Low-birthweight is the ideal measure of morbidity as it can be compared to other studies and corresponds with current national policy concerns. The results of these introspective practice reviews will allow for the modification of risking systems, making them more applicable to family practice. In the meanwhile, as Lesinski implies, there is little substitute for "good clinical judgment."[8]

William G. Sayres, Jr., MD
Department of Family and Preventive Medicine
The University of Utah
Salt Lake City

References

1. Wall E: Assessing obstetric risk. J Fam Pract 1988; 27:153–161

2. Welch HG, Larson EB: Dealing with limited resources. The Oregon decision to curtail funding for organ transplantation. N Engl J Med 1988; 319; 3:171–173
3. Hobel CJ, Hyvarinen MA, Okada DM, et al: Prenatal and intrapartum high-risk screening. 1. Prediction of the high-risk neonate. Am J Obstet Gynecol 1973; 117: 1–9
4. Casson RI, Sennett ES: Prenatal risk assessment and obstetric care in a small, rural hospital: Comparison with guidelines. Canadian Med Assoc J 1984; 130:1311–1315
5. Rosenblatt RA, Mayfield JA, Hart LG, et al: Outcomes of regionalized perinatal care in Washington state. Western J Med 1988; 149(1):98–103
6. Sayres WG Jr: Assessment of Prenatal Risk Factor Analysis and Obstetrical Outcome in a Busy Urban Family Practice. Presented at N.A.P.C.R.G. Conference, Baltimore April 13, 1986.
7. Scherger JE: Assessing obstetric risk, commentary. J Fam Pract 1988; 27:162–163
8. Lesinski J: High-risk pregnancy: Unresolved problems of screening, management and prognosis. Obstet Gynecol 1975; 46:599–603

FIRST VS LAST NAME PREFERENCES OF PATIENTS

To the Editor:

The article of Bergman et al entitled "How Patients and Physicians Address Each Other in the Office" (*J Fam Pract 1988; 27:399–402*) is indeed an interesting study. Some of the conclusions reached concerning the preference of patients in addressing physicians by their first name may be excused by the majority of patients being younger than 49 years old. In geriatric practice, such as my own, where the preponderance of patients seen are over 65 years old, the vast preference of patients surveyed prefer to be referred by their last name and prefer to refer to the physician by his last name.

In our practice we also have two male physicians, both in their late 30s. It has been anecdotally noted that in our practice most complaints voiced to physicians, threats for legal action against the practice, or difficulties in contestations of financial arrangements in the office have come from those patients who demand to refer to the physician by his first name. It would be interesting to see whether other practices, indeed, had experienced similar circumstances.

Roman M. Hendrickson, MD
Ormond Beach, Florida

To the Editor:

It is of interest that Bergman et al (*J Fam Pract 1988; 27:399–402*) found that most respondents in their study who expressed a preference wanted their physicians to address them by their first names rather than by their family names. This information appears to have been carefully gathered and appropriately studied, and it is undoubtedly valid for the study population. It may be of only limited general application, however, for the following reasons:

First, it appears that at least 75 percent of respondents were established patients of the practices in which they were interviewed; one should be cautious about assuming that they would have had the same preferences on their first visits.

Second, these findings from Seattle are somewhat discordant with our own unpublished data and with common observations in other parts of the United States; more formal modes of address may be preferred in other geographical areas.

Third, people tend to avoid health care settings where they feel uncomfortable, so some self-selection may have occurred in the population studied, as patients chose to stay or leave the practices depending on how they felt about the interpersonal styles in use there.

Fourth, only 28 percent of respondents were over 50 years of age, and it is quite possible that an older population might have had different preferences. As might have been expected, patients in the university practice (where the physicians were younger than in the other sites) were more likely to prefer to address their physicians by first names than was the case elsewhere.

The authors correctly note in their concluding paragraph that it is wise to ask patients which style they prefer.

Robert D. Gillette, MD
Family Practice Residency Program
St. Elizabeth Hospital
Medical Center
Youngstown.
Andrew T. Filak, MD
Department of Family Medicine
University of Cincinnati
Ohio

To the Editor:

We applaud Drs. Bergman et al for their article, "How Patients and Physicians Address Each Other in the Office" (*J Fam Pract 1988; 27:399–402*), which we feel expands the scanty literature on this important issue of daily patient care. At the University of Florida we have developed a seminar in which interviewing skills are taught by videotaping simulated patient encounters. Well over 300 students have taken this seminar over the past six years. The issue of "how to introduce" and "how to address" is discussed each session. We would like to share some of the points we emphasize in our seminar that complement those made by Drs. Bergman et al.

1. There is no *one* right approach for introduction and address. Learning an overall best approach (which, if uniformly used, is pleasing and appropriate to most people) is useful, but should be tempered by the fact that a small number of individuals may not respond optimally to any best approach. We advise being prepared to individualize and modify one's technique for any given case.

2. Although setting standards for interviewing is a laudable goal, in-

continued on page 333

continued from page 329

flexible adherence to any one method or approach may sometimes be perceived by the patient as patronizing or insincere.

3. Asking the patient how he or she would like to be addressed is a step forward, but may not necessarily attain the desired goal of determining the patient's true feelings. For example, some adults may feel it pretentious to say, "I prefer that you call me *Mr.* Jones," and feel almost obligated to offer to be called by their first name.

4. There is no rule that says equality of address style is essential. Just because the patient allows first name use does not require the provider to offer the same. Under certain circumstances doing so may actually be counterproductive and play right into the hands of the manipulative, histrionic, or seductive patient who tries to use the provider's first name as a method of control.

Our approach to these issues is to suggest that the provider determine appropriate titles by asking the following question: "Will it be all right to call you Mr. Jones?" Those who prefer surname use simply say, "Yes," whereas most individuals who favor first name use will respond with something like, "Actually, John will be fine." Of course, even this approach may result in the submissive or passive individual saying, "Sure," rather than stating their true preference to be called by first name. But in such cases, it is probably better to err on the side of formality.

Approximately 30 percent of medical students who have passed through our seminar report personal experiences where inappropriate use of their first name (eg, one student named Frederick, who went by *Rick,* and hated to be called *Fred*) or appropriate use of their last name or title distanced them from an interviewer. In an age where the public's perspective on the physician-patient relationship has flagged, the physician would do well to maximize tools which enable attainment of the optimal communicative relationship with their patients, beginning by use of the appropriate name.

Louis Kuritzky, MD
Ken Grauer, MD
Department of Community Health and Family Medicine
University of Florida, Gainesville

CONTRAINDICATIONS TO LIVE-VIRAL IMMUNIZATION

To the Editor:

In a recent American Academy of Family Physicians publication, *Immunization Guidelines,* it is stressed that immunocompromise of whatever cause, including autoimmune deficiency syndrome (AIDS), is an absolute contraindication to live-viral immunization with either measles, mumps, and rubella (MMR) or oral poliovirus vaccines (OPV).[1] While the admonition to avoid live-viral vaccines in patients with immunocompromise is valid in most immunodeficiency states, the situation in human immune virus (HIV) infected children appears to be somewhat different. As family physicians may be called upon at times to provide primary care for pediatric AIDS patients, some clarification of the use of OPV and MMR in HIV-infected children seems warranted.

An enhanced inactivated (killed-viral) polio vaccine has recently become available in this country.[2] Because this new vaccine is as immunogenic as the original oral vaccine, it should replace OPV for vaccination of HIV-infected children.

At present, the only vaccine available against measles, mumps, and rubella is the MMR, an attenuated live-viral vaccine. Despite the theoretical concerns about live-viral vaccine use in immunocompromised pediatric AIDS patients, the existing data to date have failed to demonstrate empiric support for these fears. A recent retrospective review of 23 symptomatic HIV-infected children given an MMR vaccine after onset of their disease revealed no instances of adverse complications following these vaccinations.[3] Additionally, case reports continue to demonstrate the increased severity of measles in HIV-infected children.[4]

Based on these considerations, the Immunization Practices Advisory Committee (ACIP) recently promulgated the following set of recommendations: (1) MMR is to be administered to all asymptomatic HIV-infected children at 15 months of age; (2) MMR vaccination is to be "considered" for all symptomatic HIV-infected children at 15 months of age.[5] These guidelines are in line with those of the World Health Organization, which has recommended MMR vaccination for all children in developing countries regardless of their HIV or symptom status.[6] Prospective studies are currently being planned to better understand the benefits and risks of MMR vaccination in HIV-infected children. Until these data are available, routine MMR vaccination of HIV-infected children at 15 months of age would appear to be warranted. Physicians caring for HIV-infected children should consult the formal ACIP supplementary statement for a complete discussion of vaccine use in these children.[5]

James D. Legler, MD
Departments of Family Practice and Pediatrics, University of Texas Health Sciences Center at San Antonio

References

1. Hess GH: Childhood Immunizations, *Immunization Guidelines.* Kansas City, Mo, American Academy of Family Physicians, 1988, p. 2
2. Immunization Practices Advisory Committee: Poliomyelitis prevention: Enhanced-potency inactivated poliomyelitis vaccine—Supplementary statement. MMWR 1987; 36:795–798
3. McLaughlin M, et al: Live virus vaccines in human immunodeficiency virus-infected

children: A retrospective survey. Pediatrics 1988; 82:229–233
4. Immunization Practices Advisory Committee. Measles in HIV-infected children, United States. MMWR 1988; 37:183–186
5. Immunization Practices Advisory Committee: Immunization of children infected with human immunodeficiency virus—Supplementary ACIP statement. MMWR 1988; 37:181–183
6. Global Advisory Group, World Health Organization: Expanded programme on immunization. Weekly Epidemiological Record 1987; 62:8

SMOKING CESSATION

To the Editor:

An interesting article by DiFranza et al[1] appeared in a recent issue of the *Journal* concerning smoking-cessation counseling by family physicians, with quotations from British general practitioners. We have recently developed a similar experience, comparing a physician-centered approach with a patient-oriented counseling technique (without nicotine chewing gum) in a practice of general medicine at Toledo, Spain. This letter is to briefly summarize our results to compare them with studies in Britain and the United States.

From March to December 1987, at the first visit of each person 15 years old or older, the patients were asked whether they smoked. If the answer was affirmative, they were appointed at random to an experimental or control study group. In the first group, educational counseling was offered to encourage them to stop smoking,[2] while in the control group only routine counseling was offered related to the health problem causing the patient to seek consultation. Of the 865 patients screened, 40 percent were smokers. Sixty-one percent of the smokers appointed to the experimental group rejected the counseling to stop smoking. Thirty cases were analyzed, and 76 controls, free from confusing factors and similar in all, who answered an evaluation questionnaire, after a mean time of 224 days of follow-up. Twenty-nine percent of those who received the patient-oriented counseling stated that they had decreased their tobacco consumption by more than 50 percent compared with 10 percent reported by the control group ($P < .05$). Our findings show high prevalence of nicotinism among the Spanish population and a high rate of rejection of the smoking-cessation counseling. Positive results of the patient-oriented counseling, however, suggest that this alternative can be effective even in situations such as the one in Spain, where social criticism of smoking has only recently developed.

Jose L. Turabián
Especialista de Medicina Familiar y Comunitaria
Centro de Salud,
Polígono Industrial
Toledo, Spain

References

1. DiFranza JR, Moser BE, Ockene JK: Smoking cessation counseling by family physicians. J Fam Pract 1988; 26:377–385.
2. Russel ML: Smoking cessation. In Behavioral Counseling in Medicine. Strategies for Modifying At-Risk Behavior. New York, Oxford University Press, 1986; pp 248–276

PRACTICE ATTRITION AND HEALTH PLAN CHANGES

To the Editor:

McWhinney and associates,[1] and Dietrich in his commentary[2] raise some interesting questions about practice attrition rates. One factor, however, not fully discussed in either article has a significant affect on practice attrition and continuity and is likely to become more important in the future.

Increasingly more Americans are receiving their health care through a managed-care plan that places some form of restriction on which physicians plan members may receive reimbursable care. Employers frequently choose from among competing plans on the basis of cost-related issues, with little attention to possible effects on continuity of care. In an increasingly competitive market place, plans have a strong incentive to minimize costs and to market their plans aggressively to employers. One consequence of these factors is a tendency for some employers to frequently change the health care plans offered to their employees on the basis of market factors.

The clinical consequence of this behavior is that patients may be compelled to leave a physician with whom they have built up a good physician-patient relationship and to transfer their care to another provider in order to receive reimbursement under a new health insurance plan. Often, the employee had little or no input into the choice of plan and, consequently, of provider. Patients are often angry at the loss of their family physician and may not approach the new provider in the most positive or agreeable fashion. The net result is practice attrition for one physician, dismay and anger for the patient, and an unhappy, upset, and wary new patient for another provider. Continuity of care suffers, and the increasingly difficult relationship between the medical profession and the public is further strained. I personally have been involved on both sides of this transfer; I expect that its frequency will continue to increase in the extremely competitive Southern California health care arena as well as in other areas of the country.

I have no remedy for this problem. I do think that family physicians, especially in the United States, need to be aware of the potential problems involved in this aspect of the "marketing" of medical care and should begin to consider strategies to minimize the burdens, both practical and

continued on page 336