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 PHYSICIAN AND MANAGED HEALTH CARE

To the Editor:

Our fee-for-service health care system has produced the most advanced, the most technical, and the most expensive health care system in the world. For all its success, this indemnity-insurance-based system is not serving well those 35 million uninsured, those 65 million inadequately insured, or those insured but struggling to pay family plan premiums in excess of $4,000. Health maintenance organizations (HMOs) may not be the answer to this multifaceted problem, but the HMO movement is a classic example of American ingenuity trying to develop a product to meet a need.

In the June issue of this journal, G. Gayle Stephens, MD, wrote "An Opposing View" regarding the HMO gatekeeper role of family physicians.[1] Dr Stephens admits that there are different HMOs and that traditional indemnity insurance is not perfect, but he then goes on to challenge the virtue and ethics of family physicians who function as HMO primary care physicians (gatekeepers). Dr Stephens' comments regarding HMO care were so negative that I feel I must share our positive feelings regarding the HMO concept of managed health care.

We are three residency-trained, board-certified family physicians providing a broad gamut of family health services in a town of 8500. Accepting the concept that managed health care should be better than unmanaged health care, we contracted with an independent practice association (IPA) HMO in 1985 and now are involved with 3 IPA/HMOs including one with Medicare-eligible individuals. We have a total of 1750 enrollees. These plans provide 100% coverage for all approved services. The only additional patient expense is a $25 co-payment for emergency department visits and outpatient counseling services. Enrollees receive significant premium reduction. The average worker saves $1500 on an annual family plan, and a Medicare-eligible couple saves $800 as compared with Medicare/Plan 65. Despite the significant reduction in premium dollars collected, these plans have always had money available to pay for all services needed, yet still reimburse our family physicians at a rate of over 125% of fee-for-service. Because of additional administrative duties, potential financial loss, and our ongoing effort at public education regarding managed health care, we feel that the 125% reimbursement is a reasonable and necessary goal.

Dr Stephens complained about his HMO patients requesting unnecessary referrals to dermatologists, chiropractors, etc. When we receive a request for what we feel is an inappropriate referral, we explain to the patient that we contract with their health insurance company to provide those services for which we are trained. We further explain that as family physicians we are trained to provide the service in question, but that if we identify the need for a service for which we are not trained or do not have the necessary equipment, then we will immediately arrange for appropriate referral.

The HMO economic incentive to physicians is not to withhold services, but to truly promote and maintain health. It is hard to envision any physician withholding needed services. HMOs are designed to reward the physician who is readily available to his or her patients and who effectively promotes health through education, lifestyle management, appropriate health screening, and timely use of specialty care.

Managed health care will not satisfy every patient or every physician. However, we have found the IPA/HMO program to be an excellent option for physicians who are committed to being always available for their patients to provide continuous, comprehensive, and cost-effective care while at the same time providing an attractive insurance option for those patients who really do want a physician who specializes in them.

Larry R. Anderson, MD
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Reference

1. Stephens GG: Can the family physician avoid conflict of interest in the gatekeeping role? An opposing view. J Fam Pract 1989; 28:701–704

The preceding letter was referred to Dr Stephens, who replies as follows:

I applaud Dr Anderson's happy experience with HMOs and regret very much giving him the impression that I was "challenging the virtue and ethics of family physicians who function as . . . gatekeepers." I apologize to him for not making it clear that I was describing ethical flaws in the gatekeeping *role* as it has evolved recently in many HMOs.

I imagine that Dr Anderson is an exemplary family physician who can make almost any system work for the benefit of his patients. Also, I suspect that he learned his practice ideals and habits in a non-HMO system of care, and that his HMOs reap benefits from seeds they did not sow. It remains to be seen whether or not HMOs can facilitate and perpetuate his virtues and skills in future generations of gatekeeping physicians.

Since Dr Anderson did not refute directly the main points of my argument, I will let them stand without further claim or defense.

G. Gayle Stephens, MD
Birmingham, Alabama

GONOCOCCAL ENDOCARDITIS

To the Editor:

Dr Olsen–Noll et al[1] have provided an interesting addition to the growing number of case reports involving endocarditis caused by *Neisseria gonorrhoeae*. Their patient demonstrated many of the features of the patients described in our review of this subject.[2] Several interesting observations concerning this infection not discussed in their report are worth noting.

In only a minority of all reported cases (10 of 34 patients in our review) was there a history of recent genital infection. This clue to diagnosis is often unavailable. Fortunately, blood cultures have been uniformly positive, except in patients with isolated pulmonic valve involvement. Prolonged incubation may be required, however. Finally, in spite of the increasing worldwide incidence of urogenital infections caused by penicillinase-producing *N gonorrhoeae*, to date endocarditis caused by this organism has *not* been reported.

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References

1. Olsen–Noll CG, Convery SR, Bosworth MF, Carmody TJ: Gonococcal endocarditis. J Fam Pract 1989; 29:305–310
2. Jurica JV, Bomzer CA, England AC: Gonococcal endocarditis: A case report and review of the literature. Sex Transm Dis 1987; 14:231–233

FUTURE PRIMARY CARE: A MERGER OR NOT?

To the Editor:

In response to the question, "Should there be a single primary care discipline for the 21st century?" I would answer a resounding "YES." And the name of that discipline should be family medicine. There is a reason why family medicine is one of the fastest growing medical disciplines in the world: it has been judged the most appropriate primary care specialty to meet the needs of all family members.

Perkoff[1] suggests that the literature does not offer any ". . . convincing evidence that supports any one primary care specialty over any other." This statement is not exactly true. The studies referenced by Perkoff indicate that family physicians have as good results as the other specialists with whom they were compared. I could not find any studies showing that other specialists could do family practice as well as residency-trained family physicians.[2]

Perkoff's position on the talent of our family medicine residents and faculty is one I found to be both provincial and arrogant. I challenge his statement that residents in other specialties do better physical examinations than family medicine residents, or that they are any more capable in making medical decisions. In addition, it is well known today that family medicine faculty have respected talents that extend beyond the realm of "social and behavioral aspects of patient care."[3]

The argument that there should be a single primary care discipline to avoid political hassles and improve financial rewards is comforting, but from my perspective, not entirely relevant. The reason for our discipline's existence must be based primarily on our teaching, research, and service contributions. In all three areas we have demonstrated we have something special to offer.[3–5]

Perkoff and Colwill[6] call family physicians generalists. I do not accept this label. I feel that the residency-trained family physician is a specialist in primary care. We are the "decathlon" athletes of medicine. We have specific areas of expertise that we combine to allow us to function as experts in our decathlon (primary care). It is possible that in a breakdown of our various "events" there may be specialists in single "events" who can outperform us. Few, however, will be found who can compete with us in our decathlon.

For most of the world, primary care and family medicine (general practice) are becoming synonymous. In the United States let us continue to advance the academic discipline of family medicine within the eclectic environment of our nonsystem of primary health care. If family medicine is the best at what it does, it will persevere.

Gabriel Smilkstein, MD
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References

1. Perkoff GT: Should there be a merger to a single primary care specialty for the 21st century? An affirmative view. J Fam Pract 1989; 29:185–188
2. Bowman MA: The quality of care provided by family physicians. J Fam Pract 1989; 28:346–355
3. Geyman JP, Berg AO: *The Journal of Family Practice* 1974–1988: Window to an evolving academic discipline. J Fam Pract 1989; 28:301–304
4. McWhinney IR: Family medicine as a science. J Fam Pract 1978; 7:53–58
5. Stephens GG: The intellectual basis of family practice. J Fam Pract 1975; 2:423–428
6. Colwill JM: Education of the primary physician: A time for reconsideration? JAMA 1986; 255:2643–2644

To the Editor:

I enjoyed reading in your August 1989 issue of the Journal the articles bringing up, again, the possible future merging of internal medicine and pediatrics into family practice (*Should there be a merger to a single primary care for the 21st century? Perkoff GT: An affirmative view. Scherger JE: An opposing view. J Fam Pract 1989; 29:185–190*).

There are several statements made by Dr Perkoff that I don't believe are true or can be substantiated. He states that "pediatricians are trained to provide more detailed and often higher quality child care over a wider range of patient problems, especially for seriously ill children." I assume he thinks that they are more highly trained than a family physician. I also noted that he did not substantiate that statement by any documentation; nor did he document his statement "Even the best of today's residents lack the sophistication in detailed physical examination, reasoning about diagnosis, and breadth of clinical acumen that characterized their earlier colleagues." I'm not sure how "early" his

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colleagues are that he is talking about, but he goes on to indicate that were family practice residents trained in specialty clinics, as are internists, they would be better diagnosticians.

In this four-page article he addresses a very important part of family medicine obstetrics in just one paragraph. In spite of increasing liability issues in that area of family practice, family physicians continue to perform obstetrical procedures, and indeed, many family practice programs are able to offer a high quality of obstetrics training.

He fails also to discuss trauma care, surgical procedures, orthopedics, and other areas in which family physicians are adequately trained and in which the pediatrician and internal medicine physician currently and in the future will not be trained.

I certainly agree with Dr. Scherger's reply indicating (and documenting) that "Numerous studies have documented that family physicians and internists have markedly different practice styles with the same patient problems."

The differences in the three needed specialties are not only identifiable and practical but also philosophical, and the concept of merger of the three into one specialty indicates a lack of understanding of the specialties, particularly family practice.

E. J. Chaney, MD
Family Practice Residency Program
St Joseph Medical Center
Wichita, Kansas

The preceding letters were referred to Dr Perkoff, who responds as follows:

Drs Smilkstein and Chaney both raise important points, which demonstrate that this subject indeed was an appropriate topic for a Controversies section of the Journal. I agree with much of what they have said, believe they have interpreted some of what I said otherwise than I had intended, and continue to disagree with others of their remaining comments.

I share Dr Smilkstein's contention that "the" primary care specialty is family practice, but I do not believe it (or any other discipline of medicine) is so well developed that it can avoid searching for ways to strengthen itself. My belief is that one of the ways it can strengthen itself is by adding strengths from other primary care disciplines. Further, the critical mass of primary physicians so developed would have a profound impact upon the organization and practice of medicine and upon medical education.

Both Drs Smilkstein and Chaney interpreted what I said as indicating a belief in the superiority of "the specialties." This is expressly not the case. It stands to reason, however, that medicine and pediatrics residents who spend more time in the care of hospitalized patients, to use just one example, would be more experienced in hospital care than residents who spend less time. And if they are more experienced, they will likely provide more expert hospital care, just as we believe family practice residents provide more expert ambulatory care, in part because they spend more time training to do it.

Family practice does provide a different and, we believe, a better style of practice than do the other specialties, but I fail to see how improved training would dilute that style. I am talking about adding strength to family practice, not subverting it to some other specialty. Certainly the broad training that, as Dr Chaney points out, is received by family physicians in such areas as orthopedics, minor surgery, ambulatory medical care, and other areas, represents strengths already existing in family practice and would be retained in any new specialty. I did emphasize that a combined specialty would resemble family practice more than either of the other two participants in a new primary care discipline.

Both my critics have taken umbrage at my contention that today's residents lack skill in detailed history taking and physical diagnosis compared with the colleagues from former times (I suppose by that term we all mean "when I was trained"). Dr Smilkstein also infers that I demean family practice faculty when I contend that internists and pediatricians might do a better job of supervising training in subspecialty aspects of medicine of use to family physicians. In fact, I speak here from personal experience with medical students and residents in family practice and other specialties whom I have encountered in the course of over 40 years in academic medicine, both in institutions in which I have worked as a faculty person and in many others where I have been a visiting professor. Today's residents in general are less adept at history taking and physical diagnosis than former residents were. I cannot document this statement with hard evidence. Nevertheless, family practice residents have less opportunity to learn these skills than do others, and it is reasonable to suggest that they are even less adept at doing them. Likewise, faculty who supervise the teaching of these skills more frequently are more likely to be better at this task as well. This is what faculty from these other disciplines have to offer us, not an overall superiority. I fail to see either arrogance or provincialism in such a view.

Other specific points deserve comment. I stated in my article that the question of obstetrics in family practice was an open one, but that surely rural family physicians would have to continue to deliver babies. Space did not permit detailed discussion of this complex issue, but Dr Chaney must know that family physicians, especially rural physicians, are quitting obstetrics in alarming numbers, and that this problem needs more detailed attention than is possible in an overall policy debate about specialties. He and I would not likely disagree about this issue except in detail.

Finally, Dr Smilkstein takes Dr Colwill and me to task for calling family physicians generalists. Here we have a semantic argument. Family physicians do general medicine. They say so, and they are justifiably proud of it. But they call it a specialty. To the extent that they do general medicine in a "special" way, such a term is reasonable. But I personally like Dr Smilkstein's other term better—family physicians are "experts" in general medicine.

In the last analysis, we should do what is best for patients. It seems silly to me for three groups to be squab-

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bling over patients and what is best for them. We should be working together to prepare the best possible physician for those patients.

Gerald T. Perkoff, MD
Curators Professor
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University of Missouri—Columbia

DIAGNOSIS OF INFECTIOUS MONONUCLEOSIS

To the Editor:

I am baffled by Dr Howard Rabinowitz's assertion (*Infectious mononucleosis presenting as Raynaud's phenomenon. J Fam Pract 1989; 29:311–315)* that his patient satisfied hematologic criteria for the diagnosis of infectious mononucleosis. As Dr Rabinowitz himself says, Hoagland's diagnostic criteria require the presence of a relative and absolute lymphocytosis together with the presence of more than 20% lymphocyte atypia.

The highest lymphocyte count given in Dr Rabinowitz's otherwise interesting case report is 48% of 9.3×10^9/L and lymphocyte atypia is only 12%—some considerable way short of full compliance with hematologic diagnostic criteria as I understand them. I agree that the benign course of his patient's illness speaks for itself, but I cannot share Dr Rabinowitz's confidence that his patient had the "typical hematological changes" of infectious mononucleosis.

James McSherry, MB ChB
Student Health Service
Queens University
Kingston, Canada

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

Dr McSherry questions the interpretation of the hematologic findings of my patient with infectious mononucleosis, who presented with Raynaud's phenomenon. As reported, this patient had a total "white blood cell count of 9.3×10^9/L (9300 mm−3), with 0.48 (48%) lymphocytes and 0.12 (12%) atypical lymphocytes." This represents a relative total lymphocytosis of 0.60 (60%), and an absolute total lymphocytosis of 5.6×10^9/L (5600 mm−3). While controversy exists regarding the percentage of atypical lymphocytes necessary to meet the criteria for infectious mononucleosis, the wide range of atypical lymphocytosis in this illness is well recognized, with some cases having only a few and others a predominance. Many references[1,2] either do not list a specific percentage or consider an elevated level to consist of more than 0.10 (10%), which my patient had.

Therefore, in addition to the typical clinical picture and serologic response, it seems to me that this patient also manifested the three central hematologic manifestations of infectious mononucleosis, a relative and absolute lymphocytosis, and an elevated percentage of atypical lymphocytes.

Howard K. Rabinowitz, MD
Department of Family Medicine
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Philadelphia

References

1. Kieff E: Infectious mononucleosis. In Wyngaarden JB, Smith LH (eds): Cecil Textbook of Medicine. Philadelphia, WB Saunders, 1988, pp 1786–1788
2. Schooley RT, Dolin R: Epstein-Barr virus (infectious mononucleosis). In Mandell GL, Douglas RG, Bennett JE (eds): Principles and Practice of Infectious Diseases. New York, John Wiley & Sons, 1985, pp 971–982

OBSTETRICS IN FAMILY PRACTICE

To the Editor:

I am writing in response to the article in the August issue of *The Journal of Family Practice* (1989; 29:179–184) entitled "Obstetric Privileges for Family Physicians: A National Study," by Gordon Schmittling, MS, and Carole Tsou, MD.

The data collected by Gordon Schmittling and Dr Tsou relating to the mid-Atlantic area of this country are consistent with our recent experience and data that were collected regarding obstetrical practice in Pennsylvania. What we learned from our 1987 data is that less than 10% of our family physicians are still doing obstetrics. What was particularly interesting in our study was that one half of these same physicians indicated that they were going to be giving up obstetrical practice over the next 3 years. A few months ago when we checked with the major medical liability insurance carrier here in Pennsylvania, we learned that only 5% of the family physicians insured in their company were covered to include obstetrical practice.

This matter creates a serious dilemma in many ways for family practice. It continues to raise the question as to obstetrics as an essential ingredient of family practice. What should we be teaching our residents? What are the essential curriculum issues for all residents? Do we want all residents graduating from our programs to be able to do at least "normal," uncomplicated obstetrics? If so, why?

Recently, the Residency Requirements Committee (RRC) reaffirmed its position that obstetrics is indeed an integral part of the family practice curriculum. Even family physicians who no longer do obstetrics thought that obstetrics should remain as part of the curriculum.

In the Lancaster program we have determined three levels of competency skills so that the obstetrics curriculum is relevant to the needs and expectations of our graduates and their practice situation. Level I competency skills include competency in prenatal care, with labor and delivery experience, which gives the resident a good understanding and experience with routine obstetrics. Level I also includes skill in the management of common gynecologic problems, resuscitation of newborns, and even first assisting in a cesarean section. The latter is a common expectation in many community practices. Level II includes all of Level I, plus competency in labor and delivery. Level III is competency in high-risk obstetrics to include cesarean section capability.

We believe this model has worked well for the Lancaster program, and as a Residency Assistance Program (RAP) consultant, I have witnessed

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similar variations of these levels of competency skills in many programs throughout the country.

The Pennsylvania study would suggest that the problem boils down to economics. The problem is economics of time, energy, and money. Lifestyle issues, plus medical liability costs and competition for physicians' time in the office, hospital, and home, are all contributing to the problem. Unless the system includes adequate economic incentives to compensate for these impingements, we will not see a resolution of the problem.

Nikitas J. Zervanos, MD
Lancaster General Hospital
Lancaster, Pennsylvania

BALINT GROUPS

To the Editor:

Drs Pomeroy[1], Schwenk[2], and others interested in Balint groups might be interested in hearing about the formation of the Balint working group of the Society of Teachers of Family Medicine (STFM).

We are endeavoring to promote Balint training in the United States by training more group leaders, networking interested group participants, publishing a newsletter, and creating educational opportunities at regional and national STFM meetings. We are developing a relationship with the International Balint Federation. Finally, we are exploring the possibility of "Balint group by teleconference."

If anyone desires more information about our activities please write or call: Bob Dozor, MD, Medical Director's Office, Community Hospital, 3325 Chanate Road, Santa Rosa, CA 95404. (707) 576-4062.

Bob Dozor, MD
Frank Dornfest, MD
STFM Balint Working Group
Santa Rosa, California

References

1. Pomeroy DP: Balint groups and difficult physician-patient relationships, letter. J Fam Pract 1989;29:16–17
2. Schwenk TL, Marquez JT, Lefever LD, Cohen M: Physician and patient determinants of difficult physician-patient relationships. J Fam Pract 1989;28:59–63

OBSTETRICS IN FAMILY PRACTICE

To the Editor:

The recent article on obstetric privileges for family physicians almost certainly overestimates the current percentage of AAFP active members performing obstetrical deliveries.[1] The study was performed a year ago and is not reflective of current obstetric practice in at least three states.

A recent survey of the approximately 1400 active members of the Florida Academy revealed a total of 25 members who were still engaged in obstetrics. Eight of these were in the military, three were faculty members in family practice residencies, and only 14 were in private practice.

According to Dr. Nikitas J. Zervanos (personal communication), a survey of family physicians in Pennsylvania performed by the Research Division of the Department of Family Medicine at Jefferson College showed that only 9.8% of Pennsylvania Academy members were performing obstetrical deliveries and one half of them were planning on discontinuing this service in the next 3 years.

Dr James G. Jones, President of the AAFP, recently reported that in North Carolina the number of family physicians providing obstetrics dropped from 500 to 50 in a 2-year period because of the cost of malpractice insurance.[2]

It is difficult to reconcile these data with those collected by Mr Schmittling and Dr Tsou. However, it seems obvious that family physicians are discontinuing obstetrics, and data that are 1 year old are already out of date. It seems appropriate not to utilize this figure of 28.7% as an accurate percentage of AAFP active members still performing obstetrical deliveries in 1989.

William L. Stewart, MD
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References

1. Schmittling G, Tsou C: Obstetric privileges for family physicians: A national study. J Fam Pract 1989; 29:179–184
2. *AAFP Reporter* 1989; 16(6)

OBSTETRIC PRIVILEGES IN FAMILY PRACTICE

To the Editor:

I appreciated the recent article by Schmittling and Tsou regarding obstetric privileges for family physicians (*Schmittling G, Tsou C: Obstetric privileges for family physicians: A national study. J Fam Prac 1989; 29:179–184*). Unfortunately, the synopsis of the article provided in the table of contents of the magazine was somewhat misleading. This synopsis alleged that 90% of the survey population had obstetrical privileges when in fact the article said no such thing.

Although the survey results are interesting, it is unclear that the standardized normal Z test is the most appropriate statistic for analysis of the data in the survey. Use of this test required *many* comparisons between proportions, which casts doubt on the significance of the differences between some of the comparisons. If the point of the comparison is merely to prove that there are regional differences, then use of a chi-squared statistic to compare all of the regions simultaneously is adequate and does not require multiple comparisons.

William Renfroe, MD
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Bowman Gray School of Medicine
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MICROCOMPUTER-GENERATED REMINDERS

To the Editor:

The article in the September 1989 issue of the Journal entitled "Microcomputer-Generated Reminders: Improving the Compliance of Primary Care Physicians With Mammography Screening Guidelines" (*Chambers CV, Balaban DJ, Carlson BL, et al: J Fam Pract 1989; 29:273–280*) caught my attention because for the past 4 years I have been using computers for patient medical records in my office. This program was developed in my office and proved so successful that we have been marketing it as The S–O–A–P Patient Medical Record System. We have been offering this program to medical schools and teaching institutions, free of charge, for use in their institutions either for keeping medical records on their patients or as a teaching modality for their residents. We have approximately 25 medical schools that are using it.

This medical record system will send out reminders not only for mammograms, which I do routinely, but also for Papanicolaou smears, immunizations, screenings, birthday cards, etc. All this is built into the medical record system. In addition, it gives us the capability of sending notices to patients about drugs, drug recalls, drug warnings, etc. Patient lists are generated by the S–O–A–P Data Search Program, and the patient mailing labels are also printed by the S–O–A–P System. Besides these capabilities, S–O–A–P automatically flags patient charts for drug interactions, side effects, allergic reactions, and so on.

Further information on this option is available by writing to: Dr Sherman A. Hope, Medical Director, Patient Medical Records, Inc, 901 Thaoka Rd, Brownfield, TX 79316 (telephone 806-637-2556).

Sherman A. Hope, MD
Patient Medical Records, Inc
Brownfield, Texas

GENOGRAM AND FAMILY DYNAMICS

To the Editor:

Erstling and Devlin's article made some important points relevant to good physician-patient communication (*Erstling SS, Devlin J: The single-session family interview. J Fam Pract 1989;28:556–560*). I was disappointed, however, in the lack of inclusion of the use of the genogram. This was especially missed in the "exploration" section of the article, where resources and family dynamics were discussed.

The utility of the genogram has been discussed in other articles. The point worth emphasizing here is that a genogram is a concise way to obtain many of the data that the authors state as important in the interview, including the total number of family members and previous episodes in the family that may bear on the current clinical situation, such as deaths, similar illnesses, and so on. The genogram also frequently serves as a visual cue to gather information from family members otherwise overlooked. These data, obtainable from a genogram, can be gathered quickly and well within the context of a single-session interview.

Joseph A. Troncale, MD
The Reading Hospital and Medical Center
Reading, Pennsylvania

The preceding letter was referred to Drs Erstling and Devlin, who respond as follows:

We agree that the genogram is an effective method for recording and clarifying family dynamics. In fact, we incorporate it regularly in the family interviewing conferences that are scheduled monthly in the residency program where we teach. The genogram can be an invaluable tool in the single-session interview, provided the interviewer is adept in using one and can apply it in a focused way to interview goals.

Susan S. Erstling, PhD
Jo Devlin
Shadyside Hospital
Pittsburgh, Pennsylvania

CORRECTION

In the article "Endometrial Sampling: Analysis of 310 Procedures Performed by Family Physicians," by Rosenthal, Perrapato, Doemland, et al (*J Fam Pract 1989; 29:249-256*), the author found errors on Tables 1 and 2 after publication.

In Table 1, page 250, in the column headed 40-49, No.(%), the first entry should read 74(70).

In Table 2 on page 251, under the column heading Noncontraceptive Hormone Use, No.(%), the second entry should read 7(19). Under the column heading Other, No.(%), the first entry should read 2(5).