

LETTERS TO THE EDITOR

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BELIEFS ABOUT CANCER SCREENING

To the Editor:

We were pleased to read the recent paper by Montano et al on the psychological factors underlying family physicians' beliefs about cancer screening (*Montano DE, Manders DB, Phillips WR: Family physician beliefs about cancer screening: Development of a survey instrument. J Fam Pract 1990; 30:313-319*); attempts to understand the psychological individual differences among family practitioners is a useful first step in understanding the causal agents of practice variation.

One particular section of the work by Montano et al deserves further discussion. They interviewed family physicians about their attitudes toward cancer control activities. Without specific prompting, a number of physicians noted that their choice of cancer control methodology was influenced by some critical events in their past. Twenty-two such events are listed in Table 4 of the work by Montano et al. Seven of these critical events have to do with the cancer experienced by the family physicians' relatives, friends, or professional acquaintances. Ten of these critical events have to do with cancer experiences of a single, past patient. The citing of these particular types of critical events appears to be a textbook example of the "availability heuristic" in action. Sox et al¹ define this heuristic (or mental shortcut to decision making) as follows: "The probability of an event is judged by the ease which the event is remembered." To illustrate their definition of the availability heuristic, Sox et al note physicians who overrate the probability of a disorder based on particular, easy-to-recall personal experiences.

A specific example of this heuristic in action is the subject interviewed by Montano et al who stated that her or his attitudes toward the use of occult stool blood testing was influenced by the experience of knowing a medical school professor who died after having colorectal cancer misdiagnosed. This experience, while certainly tragic, seems to have led this subject (family physician) to inflate the perceived prevalence of colorectal cancer in her or his patient pool. To guard against the improper use of availability heuristics, we must always ask whether we are remembering only the easy-to-recall cases and forgetting about the many patients, relatives, friends and acquaintances who could have developed disease X, but failed to.

We wish to note that physicians are by no means the only persons susceptible to this heuristic method. It has been observed by a number of researchers in a wide range of subject groups and contexts.²⁻⁴ Additionally, Hogarth⁴ argues that the use of heuristics might be adaptive in a Darwinian sense. Since the availability heuristic makes for more conservative clinical decision making (ie, prevalence rates seem higher than they probably are), it does have its bright side. However, given today's limited health care resources, we can afford only so much conservatism.

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BIOPSYCHOSOCIAL MODEL

To the Editor:

Dr Medalie¹ has made a significant contribution to the development of the biopsychosocial model and its application to the practice of family medicine. Obviously the model has not yet been widely accepted by the medical community, or Dr Medalie's apology would not be necessary. It is instructive to compare Dr Medalie's paper with the model first proposed by Dr Engel² in 1977, specifically in light of my recent discussion³ of the problems inherent in the model as described by Dr Engel.

Several changes in the model have been made that will go far in gaining acceptance for the model from the mainstream medical community. The strong antireductionism, which was a central aspect of Dr Engel's argument, has been rejected. Data from reductionistic biochemistry as well as epidemiology are given their proper place in the scientific understanding of disease and illness, thus reaffirming the basic unity of science.³ The focus on the individual's idiosyncratic affective response to illness has been replaced by an understanding of the commonalities of disease and illness in patients. The interpretive, psychoanalytic methodology of Dr Engel has been replaced by the observational methodology of the natural scientist. Dr Medalie's methods are consistent with the best scientific methods in medicine.

Patient care, ie, therapeutic medicine, is, however, conspicuously absent from Dr Medalie's paper. This lack of therapeutic emphasis is a common problem in the biopsychosocial literature. As Dr Brody⁴ observes, therapeutic interventions based on the biopsychosocial model have been disappointing for the most part. Since patient care is the primary concern of practicing family physicians, this lack of therapeutic efficacy makes the biopsychosocial model irrelevant for day-to-day practice.

The biopsychosocial model as described by Dr Medalie is valid for its stated purpose, the understanding of human disease and illness in the larger context of the family, the environment, and society. It is not a valid medical model, however, because it does not address the central question of patient care. It is time for the biopsychosocial community to accept therapeutic medicine as the primary goal of medicine, and to apply their insights toward that goal. Then the model can make its insights available to the practicing family physician on a day-to-day basis.

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INPATIENT TREATMENT OF UNCOMPLICATED HEADACHES

To the Editor:

In relatively rare but important instances, headaches signal serious disease that requires immediate inpatient care. Sorting out these cases

from the far more common benign headaches is a problem familiar to all primary care clinicians. Inevitably some patients are hospitalized for what is initially feared to be an intracranial lesion, but what upon further evaluation is discovered to be a benign headache.

According to the National Hospital Discharge Survey (NHDS), there has been a recent decline in the number of patients discharged from nonfederal short-stay hospitals with a first-listed diagnosis of uncomplicated nonmigrainous headache (ICDA-8: 306.8, 791; ICD-9-CM: 307.81, 784.0) (Figure 1).¹ In the absence of recent major therapeutic advances, this decline may represent increased accuracy in the outpatient diagnosis of the common headache. One factor that may have contributed to this recent increased diagnostic accuracy is the coincident increased availability and utilization of outpatient computed tomographic (CT) scans.²

Controlling technology has been targeted as an important means of slowing the ever-growing cost of US health care.³ In the case of CT scanning and headaches, however, primary care physicians have been found to use this technology quite selectively. A recent survey reported that primary care physicians scan

fewer than 1/20th of headache patients who meet National Institute of Health CT head scan criteria.⁴ Before policies are instituted that restrict the availability of diagnostic testing, careful assessment is needed of the probable medical and economic consequences. In the case of headaches and CT scans, judicious outpatient assessments may reduce costly and unnecessary inpatient care.

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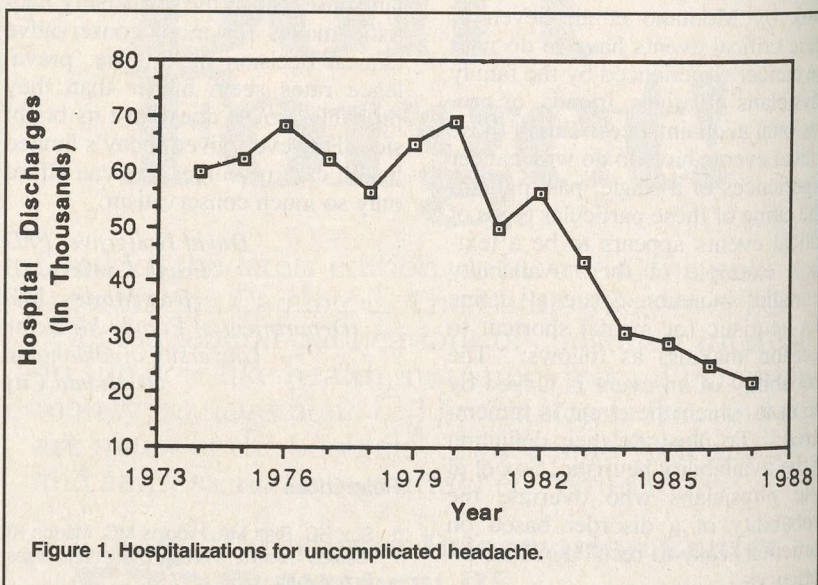


Figure 1. Hospitalizations for uncomplicated headache.

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UNIVERSAL HEALTH INSURANCE

To the Editor:

Dr Frisof's advocacy¹ of universal health insurance is a subject about which it can be said of every true statement: "While this is true, it is not all that is true." He asserts that health care is a "social or public commodity to be distributed . . . on the basis of need." Are food and shelter other examples of public commodities? If so, I can understand how to distribute food on the basis of need (a sated person is unlikely to ask for more flour or milk), and I can understand how to distribute shelter (a wet person needs a roof over his head), but I do not understand how to distribute health care on the basis of need. A need is for something that is really good for you. My experience with patients is that they very often want health care they do not need, which makes health care different from food and shelter. If need is defined, as Dr Frisof seems to define it, as desire, then we will simply stop rationing health care by providing it to those who can pay, and start rationing it by providing it to those who can wait. Without some economic barrier, perhaps based on some percentage of a patient's last year's taxable income, we will flood the primary care physician's office with patients who have a transfinite demand for a finite resource. No physician will have time to obtain a history from the patient (I have read, but do not know if it is true, that the British general practitioner spends an average of 3 minutes with the patient), and the headache caused by a brain tumor or histamine cephalgia will not timely be distinguished from the headache caused by tension or migraine, leaving the patient the worse off.

When Dr Frisof argues that this government monopsony will control costs effectively, are his actually existing paradigms the Veterans Administration and the military health care systems? The post office? Or compulsory public schooling, where despite ever-increasing spending, Scholastic

Aptitude Test scores continue to drop?

While there is much left to say about Dr Frisof's thoughtful essay, I will comment only on his last point: that new procedures be restricted governmentally to a "limited number of sites." Does this not frighten him? It does me. The ultimate consequence of that system would be that only those physicians and patients with political power will provide and receive those new procedures. However imperfect and corrupt any other system may be, it pales in comparison with the breathtaking abuse inherent in any political system of awarding health care.

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PRACTICE MANAGEMENT TRAINING

To the Editor:

We read with interest the article by Daugird and Spencer (*Daugird AJ, Spencer DC: The perceived need for physician management training. J Fam Pract* 1990; 30:348-352) wherein it was reported that medical students, family practice residents, and graduates of a family practice residency program had indicated the importance of, along with their own inadequate training and competence in, practice management skills.

The authors' questionnaire was based on a conceptualization of the term *practice management* that included 18 specific management areas. A broader definition would include those skills that allow the physician to work effectively with others, such as fostering effective teamwork, understanding the impact of one's personal style, giving and receiving feedback, and the ability to manage conflict.

As one of us has reported

elsewhere,¹ resident retreats can be designed to address some of the above areas. Though not as well publicized, training activities have also existed for the past 7 years in the form of an annual Pediatric Chief Resident/Program Directors Conference, attended by participants from all over the country. In addition, in response to requests for more in-depth training, an intensive Pediatric Chief Resident Leadership Training Program has been given for the past 3 years with increasing numbers of attendees each year. The success of this program has led to a similar course being offered this year to family practice chief residents for the first time. An article describing the course has recently been submitted for publication.

The article by Daugird and Spencer and our experience both confirm the need for such important augmentation of physician training.

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A 'NEW' CANDIDAL VAGINITIS RISK FACTOR?

To the Editor:

Recent articles by Reed et al^{1,2} in the *Journal of Family Practice* have considered factors known or thought to predispose a woman to candidal vaginitis. These risk factors include diabetes mellitus, antibiotic administration, hyperestrogenic states such as pregnancy or administration of

high-estrogen oral contraceptives, dietary intake, sexual practices, colonization status of sexual partners, immune function, obesity, and a moist perineal environment.³ Heidrich et al⁴ have quantified the association between candidal vaginitis and wearing of moisture-trapping, synthetic-fabric garments.

Vinyl car seats may also lead to perineal moisture retention but, to our knowledge, have not been assessed as a candidal vaginitis risk factor by other researchers. A potential role for vinyl car seats in predisposing a woman to candidal vaginitis is, however, suggested by clinical experience. In the past 2 years, one of us (L.L.) has encountered several women without other predispositions who developed candidal vaginitis following long automobile trips on seats of this type.

To provide empirical data, we in-

quired about car seat material while evaluating women enrolled in a study of antibiotic-induced candidal vaginitis (AICV). We found that 15 of the 23 (65.2%) who developed AICV owned cars with vinyl car seats. In comparison, only 18 of the 45 (40%) who remained free of AICV had car seats of this type. This difference was statistically significant ($P < .05$) using a chi-square test of homogeneity.

These observations are suggestive, but inconclusive. Confirmation by other investigators is needed, as is research defining the importance of car seat material as a candidal vaginitis risk factor relative to other known risk factors. We would also expect future research to demonstrate "dose-response" associations with the amount of time driven and the amount of time spent in vinyl seats at work or at home. We welcome the comments of others and present our

findings as a hypothesis for future inquiries.

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CORRECTION

In the May issue of the Journal, the Grand Rounds article (Goldberg H, Wall EM, Eicke FJ: Suspected Child Sexual Abuse. *J Fam Pract* 1990; 30(5): 523-532) was incorrectly sequenced because of an error made at the printer. The following text should be substituted for page 529. (Reprints of the article are available, free of charge, from the publisher.)

variation in what the hymen looks like in a 13-year-old. I was wondering what her hymen looked like.

DR STEINBERG: Her hymenal tissue had scalloped edges, yet it was not gaping or scarred.

DR GOLDBERG: We had been used to thinking of *Gardnerella vaginalis* infection as a sexually transmitted disease and its presence indicative of sexual activity. Bump and Buesching,² however, recently demonstrated no significant difference in prevalence of bacterial vaginosis or isolation of *G vaginalis* in virginal as opposed to sexually active girls. Based on these data, I do not think we can say that the presence of *G vaginalis* necessarily confirms sexual activity. *G vaginalis* is part of normal vaginal flora, and it appears to overgrow in certain situations. It does not necessarily initiate itself as a sexually transmitted disease, but it can be transmitted sexually.

DR STEINBERG: My understanding was that the authors of that study selected their population from friends and acquaintances of their teenage daughters. Determination of sexual activity was entirely through self-report.

DR GOLDBERG: The authors stated that for any positive results, they reexamined and retok a history specifi-

cally requesting whether the subject was sexually active. None of the subjects on questioning changed her history.

DR STEINBERG: I think we all have questions about the reliability of self-reported sexual activity. It seems clear, however, that one cannot use the presence of *Gardnerella vaginalis* as an absolute marker of sexual activity. In this patient, the presence of *G vaginalis* is little more than an additional suggestion of sexual activity, especially in the context of historical factors and her clinical presentation.

DR WALL: Is there a possibility that the different reactions to the pelvic examination were due to the sex differences of the examiners? I am also curious about the family's reaction to the psychiatry referral.

DR GOLDBERG: Sex differences could certainly have accounted for the different reactions of this patient. The patient's father consistently refused or was otherwise unable to recognize possible psychological reasons for his daughter's illness. He reluctantly accepted our recommendation that his daughter undergo a psychiatric evaluation.

DR HOLLADAY: We clearly stated to the family that we also were very concerned about the patient's symptoms even though we did not completely understand them. We thought, but did not immediately state to the parents, that much of the history was quite suggestive of sexual abuse. There was a reliable letter and some very unusual sleeping arrangements. There are some dynamics in the parents' histories that were suggestive of some problems. The mother was from an alcoholic family, and we know that she was making a lot of excuses for her