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. All letters that reference a recently published Journal article are sent to the original authors for their reply. If no reply is published, the authors have not responded by date of publication.

Advance Directives

To the Editor:

Given the recent attention to advance directives in the medical and lay press, I read with great interest Dr Glenn Rodriguez's opposing view of "Routine Discussion of Advance Health Care Directives: Are We Ready?"[1] Since the time of this article's preparation in late 1990, some noteworthy events have taken place that could have altered Dr Rodriguez's opposition to the routine offering of advance directives to patients. First, despite Dr Rodriguez's citation of the Nancy Cruzan case as supporting his conclusion, new witnesses testified in December that Ms Cruzan never wanted life-sustaining therapy.[2] In turn, the State of Missouri agreed not to intervene in light of this new testimony, and allowed her to die. Second, the Self-Determination Act of 1990[3] was passed by the Congress, requiring hospitals that receive Medicare and Medicaid payments to offer adults a written copy of the state's laws on patient self-determination and the hospital's policy on these laws at the time of admission, and to document in the patient's chart his or her advance directive status. Third, in a national survey of family physicians that was presented at the annual meetings of the Society of Teachers of Family Medicine and the Society of Health and Human Values, the degree of physician knowledge of the living will was found to have direct bearing on physician initiation of discussions with patients, as well as on physician-perceived usefulness of this advance directive.[4–6] Further, in this survey, contrary to Dr Rodriguez's postulation, a majority of physicians reported having a good familiarity with the living will and offering the living will more often to their patients. Non-offering physicians cited a variety of reasons, including not realizing that the living will was a health care option, their own discomfort, and a lack of knowledge (despite their own acknowledgment of knowing about the living will concept). The lack of disclosure to patients by these physicians in the face of increasing public awareness of and desire for the living will[7] runs counter to the clinician's obligation to preserve the patient's right of refusal.

As a result, these recent developments would tend to strengthen Dr Saultz's affirmative case, while weakening the opposing view of Dr Rodriguez. The offering of advance directives is desired by the public, will soon be required by the Congress, and is enabled by the knowledge family physicians possess at this time.

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2. Malcolm A. Judge allows removal of woman's feeding tube. New York Times 1990 Dec 15:1,9.
3. Patient Self-Determination Act (1990), OBRA of 1990, §§4206 and 4751.
4. Doukas D. A study of family physician knowledge and use of living wills in clinical practice. Annual Spring Conference of the Society of Teachers of Family Medicine; 1990 May 6; Seattle, Wash.
5. Doukas D. Informed consent and the living will. Annual Meeting of the Society of Health and Human Values; 1990 Nov 11; Chicago, Ill.
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7. Thomas P. Demand for living wills surges. Med World News 1990 Aug:40.

The preceding letter was referred to Drs Saultz and Rodriguez, who respond as follows:

We appreciate the interest and comments of Drs Deisher (*J Fam Pract 1991; 32:128–9*) and Doukas on the subject of discussing advanced directives. Events are occurring on a daily basis that contribute to the ongoing debate of this issue. We certainly agree that this debate is healthy, both for the specialty of family practice and for our patients. We also agree with Dr Doukas that there is a trend in the direction of increased dialogue within families and between doctors and patients on this issue.

We are concerned about the tendency to lump discussions of advanced directives and physician aid-in-dying into a single topic area. Combining and confusing these two very different moral issues will hinder the implementation of a more enlightened policy on advanced directives. Discussing the issue of advanced directives does not place us on a "slippery slope" that will ultimately lead to legalized physician-assisted suicides. It is of the utmost importance to clarify our thinking about the moral dilemmas surrounding the care of dying patients so that this debate can maintain a constructive and productive tone.

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Health Maintenance Protocol

To the Editor:

I write regarding the article by Hahn and Berger[1] concerning implementation of a systematic health maintenance protocol in a private practice, and the subsequent commentary by Dr Konen.[2] I agree with Dr Konen that Hahn's Table 1 is a reasonable summary of the literature to date regarding the topic of implementation of health maintenance behaviors. This literature is awkward,

however, because there is a smorgasbord of studies looking at both individual interventions and packages of targeted interventions. Additionally, there are reports from both residency training sites and private practices. I believe those studies that document improvement over time, especially for a group or package of commonly agreed upon preventive interventions, deserve careful scrutiny.

In this regard, Hahn and Berger omitted reference to our results in Iowa that documented significant improvement in residency-based physician performance over 5 years.[3] Compared to Frame's 2-year study of private practitioners,[4] our demonstration of improved physician compliance over 5 years, from 71% to 85% ($P < .0005$), with a package of major screening interventions, stands unique in the literature. This package consisted of recording blood pressure, smoking history, alcohol-use history, stools for occult blood, Papanicolaou test, and physician breast examination. Our demonstration project included the systematic placement of a health maintenance guide (age appropriate) on all adult patient charts, periodic audit and feedback to residency physicians, and periodic educational updates.

Focusing on individual interventions, our results were better than the summarized averages taken from the literature that were included in Hahn's Table 1. The following is a comparison between the results found in Hahn's literature summary and those reported by Shank et al: cigarette use, 57% vs 92%; physician breast examination, 61% vs 84%; Papanicolaou smears, 62% vs 73%; mammography, 25% vs 56%; and stool occult blood testing, 51% vs 61%.

The documented performance of Hahn and Berger over 18 months is exceptional. I support Konen's balanced discussion of the strengths and biases, with one addition. I am not convinced that Hahn and Berger could consistently stay under 4 minutes in presenting the entire package of interventions mentioned, including the detailed script in the Appendix, for adults of a variety of ages. The recording by the study physician of the time taken for this discussion is quite open to bias and inaccuracy. Ideally, this documentation of time involvement would be done by a nonbiased observer.

In summary, with specific exceptions noted above, I am glad to see this challenging study by Hahn and Berger. I agree with the authors and with Konen that a strategic, chart-based flow sheet is essential for systematic performance of health maintenance in practice. Prospective controlled studies of an adequate number of physicians and practices are desperately needed to compare the values of various inexpensive chart-based guide sheets and to confirm the importance of systematic adherence to a health maintenance protocol by the physician and office staff.

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References

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3. Shank JC, Powell T, Llewelyn J. A five-year demonstration project associated with improvement in physician health maintenance behavior. Fam Med 1989; 21(4): 273–8.
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