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. Send letters to Paul M. Fischer, Editor, The Journal of Family Practice, Department of Family Medicine, Medical College of Georgia, Augusta, GA 30912, or Fax (706) 855-1107.

RESIDENCY LEAVE

To the Editor:

I read with great interest the editorial in July 1992 by Dr Deborah Allen[1] as well as the article by Dr Nancy Baker[2] on maternity leave for practicing family physicians, and I wish to make several comments.

With regard to resident maternity leave, Dr Baker's article mentioned a policy established by the American Academy of Family Physicians for recommended parental leave for residents in training.[3] This policy recommended a 6-week leave. However, the American Board of Family Practice 1991 *Information Manual for Program Directors* states that any time off from residency in excess of 1 month in an academic year, including time off for vacation, illness, personal business, or leave, must be made up before the resident advances to the next training level, and that this time must be added to the projected date of completion of the required 36 months of training.[4]

If the resident leaves the program for whatever reason and the absence exceeds 1 month, the program director must inform the Board in writing of the resident's departure and return. Therefore, if residents choose to take 6 weeks of maternity leave, plus any vacation or sick time, in a given academic year, their graduation from the residency program will be delayed. If this was the only deterrent to taking time off for maternity leave, I would be happy to delay my graduation by 2 weeks to 1 month in order to have appropriate time to recover from delivery.

The American Board of Family Practice generally schedules the Board examination during the first 2 weeks of July. This seemingly beneficial policy of 6 weeks for maternity leave is therefore complicated by other time constraints. It is a requirement of the American Board of Family Practice that residents must graduate by June 30 of the current year in order to be eligible to sit for the examination.

On a positive note, several residency programs (mine included) have developed a research month, which can be arranged following the delivery of a child. The purpose of this month is to prepare a manuscript. All data must be collected prior to the research month.

My second general point is in reference to Dr Allen's editorial about the appropriate length for maternity leave for physicians. Several of my peers in residency have undergone pregnancy and delivery, and given the "Catch 22" scenario described above, the experience is not as risk-free as one would hope. Of my peers, one resident went into preterm labor at 37 weeks; one resident suffered two miscarriages; another resident experienced rupture of her membranes during office hours but managed to complete her appointments before checking into the hospital; another resident gave birth on the last day of her inhouse pediatric call; another resident who had problems with hyperemesis required IV rehydration and then promptly returned to complete her duties at the hospital.

Based only on my experience in 3 years of residency, I cannot say this is necessarily a national trend; however, it does concern me and my husband (also a family practice resident) about the appropriate time to start our family, both for our child's health and my own.

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4. Information Manual for Program Directors of Family Practice Residency Programs. Lexington, Ky: American Board of Family Practice, 1991:6–7.

The preceding letter was referred to Dr Baker and to Dr Young, the Executive Director of the ABFP. Their responses are as follows:

Dr Heinemeyer is correct in her description of the requirement by the American Board of Family Practice (ABFP) that a resident may not be absent from training in excess of 1 month in any one academic year to complete the required 36 months of training by June 30. She is also correct with regard to the June 30 completion date being the prerequisite to sit for the Board examination that is offered that same July.

I served on the Committee on Women in Family Medicine for the AAFP in 1987, 1988, 1989, and 1990. During my tenure as a committee member, I was engaged in numerous debates with men and women of the Academy, as well as of the Society of Teachers of Family Medicine, regarding (1) the desirability of a resident to be able to arrange a minimum of 6 weeks maternity leave, and (2) the perceived inflexibility of the American Board of Family Practice with regard to the date on which its examination is given.

In June 1988 and June 1989, I also had an opportunity to present workshops at the Family Practice Program Directors meeting in Kansas City regarding "Reduced Schedule Training Options" and "Maternity Leave Policies during Residency." Both years it was interesting to hear program directors discuss their individual approaches to the pregnant resident. Some of these men and women told their colleagues that for an uncomplicated labor and delivery, they allow a 1 month leave, to which they add 2 weeks of a reading elective. This enables the resident to complete training "on time" by June 30. In the event of prenatal or postnatal complications, or simply a desire for longer leave, they arrange a research elective, which then requires an extension of the residency beyond June 30. In addition, they require the resident to see patients 3 or 4 half-days per week in the family practice center during the extended leave. Longer leaves require approval by the American Board of Family Practice.

On more than one occasion in recent years, there have been resolutions from the National Conference of Family Practice Residents to the AAFP Congress of Delegates requesting a delay in the ABFP test date, or consideration of a second test date in late fall or midwinter. This latter recommendation would accommodate not only women who take maternity

leave during training, but men and women who request leave for other personal and professional reasons that require them to extend residency. Certainly this was an issue for those with military commitments who interrupted residency training to serve in Operation Desert Storm. Regretably, to date, the resolutions have not led to policy change.

My best understanding of the Board's reluctance to consider a second test date is that the cost of administering a second examination has been considered prohibitive. In addition, I believe the Board considers this to be an issue of concern to a minority of residency graduates and practicing family physicians. I maintain that as more women enter family medicine, and as residencies seek to make training more responsive to the personal and professional needs of all trainees, this issue should be of concern to all of us. It is to be hoped that the American Board of Family Practice will reconsider its current policy.

Nancy J. Baker MD
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Thank you for allowing me the opportunity to read and respond to the letter to the editor by Dr Lisa Heinemeyer. The issue of maternity leave and the impact of pregnancy and delivery on the female resident and her family is important and is of concern to the American Board of Family Practice.

Dr Heinemeyer has correctly iterated the current policies of ABFP as they relate to time away from the residency. Any leave from the program for more than 1 month in an academic year will result in delay of completion of the residency. In addition, if a resident is away from the program for more than 3 continuous months, the level of reentry must be negotiated. The basis for these regulations is to assure that all trainees meet a certain level of duration of training; also there are issues of continuity, which is an important aspect of family practice training.

Several alternative policies have been considered. The date of the examination, could be changed to later in the year. We studied the completion times of all candidates who were "off cycle." An analysis of this information, however, did not reveal a "best" time for examination. In addition, a survey of all the certification and recertification candidates showed more candidates favoring an early July date than any other possible time.

The possibility of providing more than one examination date has also been examined. To accomplish this, however, we would need to prepare two entirely different examinations each year. The cost would double and security would be more complex. The test editing staff, item writers, evaluation committees, proctors, and examination sites would all need to be duplicated.

The Board is beginning to develop a computerized examination. It is our belief that it will be possible to produce an exam on CD-ROM which could be conducted at any time at the convenience of the candidate and at a site near the candidate's home. It is likely to take from 3 to 5 years to perfect, but we are reasonably confident that this will allow a great deal more flexibility in test taking and still meet the validity, reliability, and security demands of a certifying examination. Such a system would allow a resident to finish "off cycle" yet still be certified within a reasonable length of time. It does not, however, solve the problem of the required continuity of care during training.

It is the intent of the Board to continuously monitor the examination process and seek reasonable solutions to any difficulties encountered. We must, however, be careful that we do not compromise the standards of quality of the specialty.

Paul R. Young, MD
Executive Director and Secretary
American Board of Family Practice
Lexington, Kentucky

FAMILY PLANNING

To the Editor:

The recent article on prevention of preterm labor[1] does not even mention improved family planning as a prevention strategy, although its importance has been mentioned frequently. The Committee to Study the Prevention of Low Birthweight concluded that "family planning services should be an integral part of overall strategies to reduce the incidence of low birthweight in infants," and urged that "subsidized family planning funds should be made generously available. . . . Title X is specifically targeted at low income women, including adolescents. As such, the program should be regarded as an important part of public efforts to prevent low birthweight."[2]

The rationale for family planning as a strategy for prevention of preterm labor is derived from the well-documented fact that women at highest risk for preterm labor (and other adverse pregnancy outcomes) are also at highest risk for having mistimed and unwanted pregnancies: poverty, age less than 18 years, age greater than 35 years, parity of four or more, interpregnancy interval less than 2 years, and late prenatal care. This relationship was well demonstrated in data from the 1982 National Survey of Family Growth: women with births that were "unwanted" at conception had a low-birthweight rate 36% higher than women with births that were "wanted" at conception (7.9% vs 5.8%).[3]

Reducing the rate of unintended pregnancies in all women, but especially among women at high risk for preterm labor, has the potential for reducing both the rate *and incidence* of preterm labor in a very cost-effective manner and may be the most effective single strategy for reducing preterm labor. Recent data from Belgium confirmed that a low level of "investment in pregnancy" (which included maternal attitude toward the pregnancy) was the best predictor of preterm labor, better than traditional risk scoring based upon sociomedical factors.[4]

Aside from the biologic risk factors of age, parity, and interpregnancy interval, there is also a behavioral basis for the effectiveness of family planning in preterm labor prevention in both upper and lower income families. Women who are not happy about their pregnancy are not likely to seek early prenatal care, or adopt a life-style conducive to good pregnancy outcome (including discontinuation of nicotine, alcohol, and other substance abuse), and they may not be good caregivers to the children they bear.[5] In spite of many recommendations for improved family planning services, especially for low-income families, the Reagan-Bush administrations reduced Title X funding by 65%, after adjustment for inflation.[6] The unwillingness of recent Republican administrations to constructively address issues involving sex, sexuality, and contraception is one of the primary reasons that the United States has higher infant mortality rates and higher rates of unintended pregnancies and abortions than any other developed country.[7]

Family physicians are uniquely able to implement the recommendations that

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"sexually active persons who do not want to have children should be counseled about methods of preventing pregnancy,"[8] and can thereby have a substantial impact on premature births, family stability, and public health. Authors of articles in our own journals should not forget the importance of family planning and our unique role in counseling about this important issue.

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PHYSICIAN ANGER

To the Editor:

A recent editorial on physician anger (*Richlin M, Sholl JG. Physician anger. J Fam Pract 1992; 35:382–4*) made me angry. Richlin and Sholl have done the profession a service by reminding us that getting angry at work can adversely affect our professional behavior. But this is not new information. Coping with this anger was their point, and it was well made. They did not mention, however, the best method of getting rid of anger. Anger or frustration is the clinical result of fear. Medical practitioners are afraid of many things these days, and I believe all of us know what these are. Instead of relaxation training, we need *combat* training. I do not want to be led to slaughter and learn how to relax on the trip. The best method of getting rid of my anger is exactly what I prescribe for my patients: identify the source and deal with it.

Luckily we know the source of our anger, and it is not the patients. The problem is that none of us can fight the system on our own. We need our professional organizations to do that for us. And they have let us down. Without a concrete plan of attack on the causes of frustration to the practitioner, relaxation techniques, or other forms of "prayer," will not have wide appeal. Ross Perot is not afraid to tackle big projects. And I hear that he is not real busy right now. Let's ask the AMA to give him a call and ask him to lead our charge on bureaucracy.

Joseph J. Baum, MD
Mount Airy, North Carolina

To the Editor:

The one part of my medical life that no one appears to wish to share is the responsibility for caring for the patient.

Everyone seems to be willing to tell us how to take care of our patients, what to do with them, when to send them home, what kind of tests they can and cannot have; however, no one is going to accept *responsibility* for caring for the patient except the physician.

What I am saying is that until someone is willing to share the risks of caring for our patients, then I think each and every physician has the duty to become the patient's representative. As the physician assumes more of this duty, he or she becomes more and more frustrated, and anger looms just ahead.

I don't believe Sir William Osler (referred to by Richlin and Sholl) would have treated Medicaid with much respect.

William W. Lyons III, MD
Kearny, Nebraska

The preceding letters were referred to Drs Richlin and Sholl, who respond as follows:

We appreciate the comments by Drs Lyons and Baum concerning our recent editorial on physician anger.[1]

Essentially, we agree with both authors and echo their calls for recognition of the unique role of physicians in patient care, and awareness of the bureaucratic barriers to full realization of that role.

Dr Baum seems to imply that we are recommending the use of relaxation training as a substitute for effective action in situations that cause anger. But our view is exactly the opposite. We stated that "anger has adaptive as well as maladaptive functions."[1(p383)] We made the point that relaxation was particularly useful for avoiding a buildup to a "last-straw" explosion of anger or rage following a series of everyday irritations. We then went on to discuss the cognitive-behavior techniques of self-instruction[2] and stress-inoculation training[3] for *managing* one's anger to "facilitate the expression of negative feelings to others in ways that lead to successful conflict resolution rather than merely escalating antagonisms."[1(p383)]

Anger *is* energizing.[4] It is our hope that physicians and their organizations will use that energy to respond to Dr Lyons' and Dr Baum's clarion calls to action against the bureaucratic barriers that physician's must overcome. We also hope that they recognize the need to manage anger in constructive ways, to avoid both the negative physical consequences of anger[5] and the interference that disruptive anger can cause in the development of constructive solutions.[3,4]

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CODING AND REIMBURSEMENT

To the Editor:

As a practicing family physician, I

will find the article on coding and reimbursement (*Zuber TJ, Purvis JR. Coding and reimbursement of primary care biopsy and destruction procedures. J Fam Pract 1992; 35:433–41*) very helpful in my practice. I am planning to copy the tables and place them in each examination room.

However, as a physician reviewer for the Southern California Pipe Trades Trust Fund, I am disturbed by the suggestion to bill a colonic mucosa biopsy with the diagnosis code for rectal or abdominal pain. I can accept this diagnosis if the patient actually has these symptoms and the colonoscopy was done to investigate. However, since polyps are asymptomatic, suggesting that physicians use this diagnosis for reimbursement in the absence of symptoms constitutes fraud. Polyps are potentially premalignant and need to be removed. As a reviewer, I would therefore approve it with the diagnosis of 211.3 for Benign Neoplasm, large intestine, or 211.4, Benign Neoplasm, rectum.

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

I appreciate the comments made by Dr Solomon. He raises an excellent point that was emphasized at the end of the paper: physicians must select the codes that accurately describe the procedures performed.[1] This is true for both CPT[2] and ICD-9-CM[3] coding.

Physicians must be honest in their reporting. Occasionally, two different CPT codes may accurately describe a single procedure, such as 19100 and 88170 for a needle biopsy of the breast.[2] Generally, only one code is appropriate and should be selected. Alternate codes should not be reported to provide higher reimbursement if they do not accurately reflect the services provided.

Many third-party payers base reimbursement on the diagnosis (ICD-9-CM) code selected. Physicians should honestly report diagnosis codes. Unfortunately, physician honesty may cause some claims to be denied. This is frequently encountered when a biopsy is performed to "rule out" cancer.[1] Third-party payers often deny payment for this reason.

In the example listed in the paper, we suggested that a symptom may be reported when a neoplasm code cannot be applied.[1] Colon biopsy may be indicated in the absence of tumors or polyps. In a patient with abdominal pain and a history of ulcerative colitis with significant mucosal changes, a colonoscopic biopsy could be billed with a diagnosis code for abdominal pain (789.0).[1]

As mentioned in the paper, physicians frequently utilize the Neoplasm, neoplastic section of the ICD-9-CM.[1] These tumor diagnostic codes frequently provide physicians with the indication for many biopsy procedures. Dr Solomon correctly identifies two appropriate neoplasm codes that can be reported if colonoscopic biopsy is performed for colonic polyps.

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D&HH PERSONS

To the Editor:

There are over 20 million deaf and hard of hearing (D&HH) persons in this country, and their number is projected to increase at a faster rate than the total population. Hearing and communication disorders cost society $30 billion yearly for care and treatment, reeducation, and lost wages.[1,2] Despite these numbers, little is known about the health status of these persons. For example, the two published reports that discuss the life span of D&HH persons reached conflicting conclusions.[3,4] Moreover, both were presented in textbooks and did not provide the data upon which the analyses were performed.

The availability of recent data on age of death for a group of D&HH persons insured by the National Fraternal Society of the Deaf (NFSD) stimulated our interest as to the life expectancy for this population. This report summarizes our evaluation of these data.

The NFSD is a private organization that has been in business since 1901 and insures approximately 10,000 hearing impaired persons. We looked at a sample of 12 issues of their bimonthly publication, *the frat,* which were continuous during one of two periods: 1975–1976 (7 issues) and 1989–1990 (5 issues). Each issue lists the names of all policyholders who have died since the previous issue, and their age at death. The evaluation reported here is limited to men.

Median (instead of mean) age at death is traditionally used for mortality comparisons between different populations because it is less affected by data outliers, and it was calculated for all men listed in the issues of *the frat.* Analysis of variance testing was used to compare the average median age at death for the two periods for which data were available.

Two hundred forty male deaths were listed (see table). There was a marginally significant effect of year of death on median age of death, with those dying

Table 1. Age at Death for D&HH Persons Insured by the National Fraternal Society of the Deaf, Compared with All US Men

	Deaths Occurring 1975–1976	Deaths Occurring 1989–1990
NFSD insured men		
Number	147	93
Mean Age at death (y)	72	77
Median Age at death (y)	75	78
Standard deviation	11.9	10.9
All US men*		
Median age at death (y)	72.9	75.6

**Vital statistics of the United States, 1987.*[5]
NFSD denotes National Fraternal Society of the Deaf.

in 1989–1990 living longer than those in 1975–1976 ($P < .1$).

Our investigation suggests that, despite the known increased number of medical problems[6] and altered health care utilization patterns of D&HH persons,[7] men insured by NFSD had a *higher* median age at death than the general population. Whether this finding is relevant or only caused by confounding factors is unclear. One potential factor is selection bias. Like many insurance companies, the NFSD may select policyholders who are economically better off and healthier than typical D&HH persons. The fact that NFSD was originally founded to insure persons who were unable to obtain insurance from traditional companies because of their deafness suggests this is not the case. It is possible, however, that the company subsequently became more selective. In addition, although it is our understanding that most clients of NFSD insured before 1975 were profoundly deaf, we were unable to obtain data about their degree of hearing loss. Thus, we could not investigate any association between this and age of death. It is interesting to note that the increase in life span of D&HH men for the years 1989 and 1990 compared with 1975 and 1976 is similar to that seen in the general population.

Assuming that the higher median age of death found for D&HH persons is correct, it is interesting to speculate as to possible reasons. Preliminary evidence at our institution suggests that these persons practice fewer adverse health habits than hearing persons, including smoking. As smoking is the leading cause of death in this country, a lower prevalence of smoking could explain an increased life expectancy for this group of people.

We are well aware of the limitations to our evaluation above. The information provided by NFSD consisted merely of the age of death of its policy holders. We did not independently validate these numbers, and the data did not provide age-specific death rates or the age distribution of its policyholders, critical information needed before one can make confident conclusions about death rates of a specific population. Nevertheless, the preliminary finding of a higher median age of death for D&HH persons is intriguing enough that we believe it should be made public. Further investigation needs to be conducted.

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