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.

BIRTH CONTROL

To the Editor:

I enjoyed the article by Dr Rosenfeld and her colleagues on women's satisfaction with birth control (*Rosenfeld JA, Zahorik PM, Saint W, Murphy G. Women's satisfaction with birth control. J Fam Pract 1993; 36:169–73*). I was disappointed, however, that all methods of natural family planning were categorized as "rhythm." There are large differences between "rhythm" and the more reliable basal body temperature, cervical mucous, and sympto-thermal methods. It is a shame that the medical profession, and family medicine in particular, is so ignorant about this method of family planning that could be quite useful and acceptable to certain populations of patients. More information about non-"rhythm" methods of natural family planning can be obtained from the Couple to Couple League, PO Box 11084, Cincinnati, OH 45211.

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VITAMIN B_{12} DEFICIENCY

To the Editor:

A recent article by Yao et al[1] recommended screening every individual over 65 years of age for cobalamin (Cbl) deficiency using the serum Cbl radioassay. However, the urinary methylmalonic acid (MMA) test by gas chromatography mass spectrometry (GC/MS) is a better screening test.[2]

The serum Cbl radioassay is unsuitable for screening since two thirds of values below normal (<200 pg/mL) may be false positives,[3–5] and some subjects with serum Cbl levels >300 pg/mL are Cbl deficient.[1,2] The urinary MMA assay by GC/MS is a functional test for true tissue Cbl deficiency. The test requires only a 1-mL random spot urine specimen, which can be mailed unrefrigerated. The test is available commercially for $50, which is comparable in cost to the serum Cbl radioassay.

Screening all elderly for Cbl deficiency by testing MMA by GC/MS was previously recommended[6] after a high incidence of permanent neurologic disability in nonanemic Cbl-deficient patients and a high prevalence of Cbl deficiency in elderly persons were discovered.[7] Complete resolution of neurologic deficits is possible if the deficiency is detected early and treated with Cbl injections.[8,9] Even a 20% increase in function, however, can make the difference between dependence and independence.

Health care costs for Americans over 65 years of age approached $300 billion in 1992.[10] It is estimated that 43% of Americans who turned 65 years old in 1990 will live in a nursing home for an average of 2.8 years.[11] Health care costs for the elderly are expected to spiral since it is estimated that the number of persons age 65 years and older will more than double over the next 40 years, from 30 million to 65 million.[12] Thus, disability prevention through early detection and treatment of Cbl deficiency will help seniors maintain their productivity, dignity, and independence while saving billions of dollars annually in health care costs.

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CHAPERONES

To the Editor:

I was flabbergasted to read the article "Patients' Attitudes Regarding Chaperones During Physical Examinations."[1] I was trained to use chaperones. I believe it is the standard of care in my area. It should be the standard everywhere, but especially in a training program.

Close to 10% of primary care physicians surveyed by Gartrell et al[2] admitted to sexual contacts with patients. My residency program learned the hard way. After a resident was terminated from my program 10 years ago, several nurses reported that he had done pelvic and breast examinations on many female patients who had come in for minor complaints. He ultimately lost his license last year when four women applying for amnesty complained about prolonged breast and/or pelvic examinations. It could happen in your residency.

How would it look if it was a faculty member instead of a resident? I was molested by a faculty member of a prominent family practice residency program 15 years ago after I sought his advice in making some career decisions. He coun-

seled me and then suggested he become my physician, offering a free examination on a Saturday. The examination was cursory except for the rectal and genital examination. He put me up in stirrups with a fenestrated drape over my penis and did a prolonged prostate massage. We were alone. Needless to say, I subsequently attended another residency program.

As evidenced by this study, patients apparently don't know what we physicians should know. The State Board of Ohio recommended that "the third party be *actually present* when the physician performs an examination of the sexual reproductive organs or rectum." I agree. We are entering an age of reporting sexual harassment. Should we wait until an unchaperoned resident or faculty member molests or is accused of molesting a patient, or should we do something about it now?

Contrary to the conclusions of this study, the preference of the patient should *not* be the determining factor in the use of a chaperone. Chaperones should be standard policy. Why give wayward physicians a license for assault? We may not be able to control what physicians do in private practice, but we should at least take appropriate precautions in a teaching program.

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AMERICANS WITH DISABILITIES ACT

To the Editor:

I read with great interest your article on the Americans with Disabilities Act (*Matson CC, Holleman WL, Nosek M, Wilkinson W. Impact of the Americans with Disabilities Act on family physicians. J Fam Pract 1993; 36:201–6*). I was disappointed, however, that the article did not directly address the impact for family physicians who hire other family physicians to work in their offices. In addition, there was no reference to the problem that credentials committees of hospitals encounter regarding the ADA.

My understanding is that the law includes mental illness and drug and alcohol abuse as disabilities. At our family practice–based institution, on occasion we are confronted with applications from physicians with recent drug or alcohol problems. The law states that we can exclude from consideration for a position only a person who "poses a direct health threat to the health or safety of themselves or others in the workplace that cannot be eliminated by a reasonable accommodation." I would be interested in the author's response to the impact of the ADA under these two circumstances.

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

Dr Tremain has correctly perceived that the Americans with Disabilities Act (ADA, "the Act") applies to health care providers who seek employment by other physicians, by institutions such as hospitals and medical schools, and other health care organizations. Therefore because a *past* history of alcoholism or emotional problems is defined as a disability by the Act, using either as sole criterion to deny employment is unacceptable. However, the Act specifically excludes current illegal drug use from the list of protected disabilities, and specifically allows drug testing for detection.

The situation in which an individual has a current alcohol abuse problem or an emotional disorder, but may not clearly be a "direct threat" to others, is more complex. In order to use such a disorder as a cause for exclusion from employment, the employer should be able to demonstrate that the disorder prevents the health care provider from fulfilling the essential functions of the position, and could not do so with reasonable accommodation. As we emphasized in the article, such an exclusion will be greatly facilitated by having a detailed job description for the employee. Given the level and complexity of cognitive skills and decision-making required of physicians, a suitable job description may be no small task. An additional wrinkle with which we will all struggle is that, because certain disorders such as depression and alcohol abuse tend to be cyclical, a potential employee may be perfectly capable of functioning as a physician at the time of job application, but is at risk for relapse of the disorder with attendant dysfunction. The greater potential for subsequent dysfunction does not appear to justify denial of current employment by itself. The complexity of fitness-for-duty decisions, especially regarding applicants with a history of emotional difficulties, has been illustrated with examples from case law by Maffeo (*Maffeo PM. Making non-discriminatory fitness for duty decisions about persons with disabilities under the Rehabilitation Act and the Americans with Disabilities Act. Am J Law Med 1990; 16:279–326.*)

Dr Tremain also raised the question of the ADA's application to credentials committees of hospitals. While most physicians are not technically hospital employees, courts may interpret having hospital privileges as qualifying physicians as employees, as they have in some malpractice cases. If this is the case, the provisions of Title 1 would apply, protecting physicians against discrimination based on a disability. If the granting of privileges is interpreted as a quasi-licensing function affecting employment, then Title 3 provisions would apply prohibiting any discrimination in licensing. In making decisions regarding privileges for physicians, credentials committees are well advised to focus on whether the physician has demonstrated ability to perform the role of a medical staff member, rather than on the perception of the effect a disability may have.

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