

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 A. Nutting, MD, MPH, Editor, The Journal of Family Practice Editorial Office, 1650 Pierce St, Denver, CO 80214, or Fax (303) 202-1539. E-mail: nuttingp@usa.net

ACETAMINOPHEN HEPATOTOXICITY

To the Editor:

Recently, there has been much publicity in the press about risks associated with the concurrent use of acetaminophen and alcohol drinking¹ and/or fasting.²

Therapeutic misadventures associated with acetaminophen present late and are seldom recognized until the occurrence of symptomatic hepatotoxicity, which can be devastating. I have encountered one patient experiencing acetaminophen toxicity. My patient was a 37-year-old "closet" drinker who was unaware that her four different physicians' brand-name prescription drugs as well as the over-the-counter drugs she was taking all contained acetaminophen. She had consumed 24 ounces of her favorite cold formula, Vick's liquid Nyquil (Procter & Gamble) for an upper respiratory infection. This product is 10% alcohol, and 1 oz contains 1000 mg acetaminophen, 60 mg pseudoephedrine, 30 mg dextromethorphan, and 12.5 mg doxylamine (a sedating antihistamine). Nausea precluded nutritional intake.

She presented to a hospital emergency department, where laboratory tests revealed glucose screen too low to measure, arterial pH 6.85, bicarbonate 3.6, aspartate aminotransferase (serum glutamic-oxaloacetic transaminase) 17,300, lactate dehydrogenase 18,570, phosphate 17.5, albumin 3.7. Four hours later, prothrombin time was 49.6 seconds, partial thromboplastin time 140 seconds, arterial ammonia 241, and acidosis unchanged. The patient was given intensive support and acetylcysteine. Transplantation services were alerted. She died 10 hours after presenting to the emergency department.

Reversible ketoacidosis in diabetic patients is a familiar occurrence, but with acetaminophen, relatively minor acidosis (a pH of less than 7.3) is a fatality marker and suggests the need for liver transplantation. A study by Lee³ indicates that acetaminophen in alcoholics is this country's single most frequent cause of acute liver failure. I believe the likelihood of medication error is far greater with liquid formulas than with pills. Pill and packet users count carefully, but liquid medica-

tion users admit to drinking directly from bottles, avoiding messy measuring, not wanting to leave the bed, being too hurried to measure, or even taking multiple "swigs" in the dark. These practices amount to supradosing to achieve the desired effect for coughs, coryza, pains, and even insomnia. While insomnia is not an indication for this type of product, users quickly learn that "nighttime" on the label indicates the presence of sedating antihistamines.

Since physicians do not always know their patients' alcohol intake and some needing relief are too sick to eat (evoking risks associated with fasting), it may be safer to revise our thinking on the subject of acetaminophen dosing and emphasize to our patients a 2-g/d maximum for this drug, stressing the importance of accurately measuring. Many physicians are far more comfortable with acetaminophen than its many competing products, and hepatotoxicity is uncommon; however, ongoing media coverage mandates physician awareness of acetaminophen safety margins in daily "social" alcohol users. The safety margins are much narrower than previously realized, even at "normal" dosages. Additionally, it is important to remember the risks associated with fasting and using acetaminophen. It is hoped that communicating our balanced concerns with at-risk patients will prevent similar acetaminophen toxicity and associated deaths.

David E. Langdon, MD
Arlington, Texas

References

1. Zimmerman HJ, Maddrey WC. Acetaminophen (Paracetamol) hepatotoxicity with regular intake of alcohol: analysis of instances of therapeutic misadventure. *Hepatology* 1995; 22:767-73.
2. Whitcomb DC, Block GD. Association of acetaminophen hepatotoxicity with fasting and alcohol use. *JAMA* 1994; 272:1845-50.
3. Lee WM. Acute liver failure. *N Engl J Med* 1993; 329:1862-72.

SUSTAINED PARTNERSHIPS

To the Editor:

Accolades to Ms Leopold and Drs Cooper and Clancy for their excellent re-

cent article "Sustained Partnership in Primary Care" (Leopold N, Cooper J, Clancy C. *Sustained partnership in primary care. J Fam Pract* 1996; 42:129-37). It provides an insightful examination of this interesting and important topic.

The last sentence of the paper states: "Provider organizations will have little incentive to develop delivery systems that facilitate sustained partnerships in primary care until research demonstrates that . . . sustained partnerships result in greater patient satisfaction, health care utilization, or health outcomes." It is not clear to me why greater health care utilization would be a positive incentive for provider organizations, or whether the authors believe that sustained partnership would be likely to increase utilization.

With regard to this latter point, while an association between the patient-physician relationship and utilization has not, to my knowledge, been reported, qualitative research from patient focus groups within my study of patient-physician trust suggests that the association may be complex. In new relationships, many patients reported that ordering tests or referrals is trust-enhancing, indicating thoroughness, concern, and technical competence. Within established trusting relationships, this association was reported much less frequently and patients instead gave examples in which trust appeared to reduce their demand for immediate diagnostic or therapeutic intervention. This observation remains to be tested using quantitative research.

David Thom, MD
Palo Alto, California

COMPUTERIZED MEDICAL INFORMATION SYSTEMS

To the Editor:

I am writing in response to the March 1996 editorial about an experience with a computerized medical information system (Lawler F, Cacy JR, Viviani N, Hamm RM, Cobb SW. *Implementation and termination of a computerized medical information system. J Fam Pract* 1996; 42:233-40).

I am the owner and medical director of a busy bilingual family practice in a

metropolitan area of southern California. For the last 3 years I have used a computerized medical information system involving the use of terminals in all the examination rooms as well as in the reception area to maintain electronic medical records of all patient encounters.

The editorial concluded by stating that appropriate software is several years away. Whoever made the initial decision and purchased Dr Lawler's system had more dollars than sense (\$500,000, to be exact). I constructed my system using software available off the shelf, and stocked the rooms with used computer equipment that continues to function quite nicely. I might add, I use Macintosh computers, which are known to be much easier to use and are relatively simple to link together. This system provides instant access to all patient visits, has current medication lists, treatment plans, allergies, immunizations, as well as a variety of other epidemiological data that can be instantly accessed and configured into different formats. Part of the database includes an automatic ICD-9 (International Classification of Diseases) look-up function that enters the diagnosis from the ICD-9 number.

With respect to evaluating a computerized medical information system, several points are worth emphasizing:

- *Be realistic.* Not all things can be automated. Although computer hacks love to think that everything should occur with the push of a button, in some cases, it is easier to use a piece of paper or have a person perform an operation rather than have it automated.
- *Know what you want the system to do.* In Dr Lawler's case, I think the users expected the system to perform too many functions. The more functions, the more complex and slower the system will be.
- *Just say no.* If you think something does not work, then it doesn't. My consultant often said, "That can't happen," but it *would* happen. It is your system, it has to work for you. If excessive learning is involved, then it is the wrong system.
- *Use in-house resources.* If you have any staff members who are computer savvy or have a high interest, let them do the research. It is cheaper to buy them a prototype computer and fool around with the proposed database than to plunge headfirst into an untested system, as these folks did.

What was lacking in this experience was management skill rather than computer technology. In essence, they approached their vendors with an open checkbook rather than a critical understanding of what they wanted.

*David J. Keulen, MD
Stanton, California*

To the Editor:

I read with considerable interest the editorial by Dr Lawler regarding implementation of a computerized medical information system (*Lawler F, Cacy JR, Viviani N, Hamm RM, Cobb SW. Implementation and termination of a computerized medical information system. J Fam Pract 1996; 42:233-40*). His experience points out several critical issues regarding such an implementation but perhaps left out the most important: implementing a computerized medical information system requires a long-term commitment and considerable intestinal fortitude. Giving up after just 3 months suggests that neither were present, and this is a very important lesson for all of us.

The Community Health Plan's Saratoga Health Center implemented a similar system in July of 1994 after 3 years of consideration and analysis of implications for health care delivery. Despite all this preparation, the first few months were a true nightmare, both because we had not anticipated all of the issues we would face and because the system did not live up to our expectations. Two years later, we now have the third version of that information system and can honestly say it has improved the care we provide and created opportunities for innovations in disease management.

The \$500,000 quoted for University of Oklahoma is indeed just a start. We have spent much more in software, hardware, interfaces, and staff time. But our perseverance and the partnership we formed with the vendor led to a much better product and, at our end, an organization that is much better prepared for future clinical system initiatives.

*Jerry Salkowe, MD
Medical Director, Capital Area
Community Health Plan
Latham, New York*

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

I congratulate Dr Keulen on his successful system. We stand by our conclu-

sion that appropriate software to handle 40,000 patient visits per year for 60 providers of varying medical and computer skills is still several years away. We have had several solo practitioners respond positively to our article with comments similar to Dr Keulen's. I envy and admire the skills and commitment that produce workable systems.

Nevertheless, in those practices there is but one customer for the system to please. With the immense complexity of resident and medical student training, research objectives, laboratory and radiology interfaces, and billing tasks, the needs of a large academic group practice are different from those of a small practice.

My compliments to my friend, Dr Salkowe, on his implementation of a system to which we failed to adapt. He indeed has succeeded where we failed. Whether we lacked sufficient commitment and guts is an open question. Among his advantages are a bigger budget and a narrower management focus. In addition to patient care concerns, as an academic institution, we need to address resident and medical student education and research objectives, all of which proved untenable with that software. It may be of interest to note that our mutual vendor has suffered a substantial mortality rate on systems that have been installed. Our site is not the first nationally to unplug from this system.

We look to the future for easy-to-use, physician-friendly software. It doesn't yet exist.

*Frank Lawler, MD
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A COMMON THREAD THROUGH FAMILY MEDICINE

To the Editor:

On my recent solo visit to France for the study of its culture and language, I had the opportunity to spend time with my friend Dr Dominique Delfieu, a French family doctor. Almost everything about the structure of Dr Delfieu's practice of general medicine is different from that in America; but everything that we value about family medicine as a care-giving specialty comes out in the generalists' practices in France.

As Dr Delfieu and I walked along the streets of his home neighborhood in north central Paris, Montmartre, we encountered several of his patients. He went out of his way to go into a shop to express kind feelings and concern for a woman aged 60 years who had lost her husband just 10 days before. In a courtyard near Sacre Coeur, we happened upon members of a family having trouble with placement of an elderly relative. Here, too, Dr Delfieu was sympathetic and concerned. As a ritual of affection during Dr Delfieu's greetings, every female acquaintance had to be kissed four times in alternating fashion from cheek to cheek. Every man was kissed twice in similar fashion, but less compassionately. How does anyone keep up with how and whom they are supposed to kiss and yet offend no one? Would any of us find this an acceptable practice with our patients now? Well, yes, most American family doctors probably do find this acceptable. We just do our kisses and hugs more often in the privacy of our offices. We express our feelings as well through means more acceptable in our culture. It is an important part of how we deliver care. I learned by observing Dr Delfieu that the open display of love and compassion for our patients has a magically powerful effect on the delivering of care and messages of good will. We are still professionals, but more than that. This is a major reason family practice remains so special and indispensable.

The private office of Dr Delfieu is located at 82 rue Lepic, which is just up the street from where Vincent van Gogh

lived and painted for a while in Paris. His office consists of one exam room, a secretary, and a small waiting room. He somehow sees 25 to 30 patients there each day. He does his own nursing and examines patients unattended (even pelvises), as almost all generalists do in France. No problems develop from this practice, or, of course, it would have changed a long time ago. The payment of \$24 per visit does not allow for the expense of an office staff and barely covers the high office rent. There is still office paperwork to be filed for government payment of services, but far fewer hassles than what we deal with in America with multiple payers. After office hours, he takes calls from patients. He drives his moped-like scooter (*une velomotor*) through narrow, hazardous streets both night and day to patients' homes. He sees six patients in their homes on most days, for another \$30 per visit. I assure you, the subspecialists of France do not join him on home visits.

At the end of our meeting, Dr Delfieu gave me a copy of his well-read book *Elle m'a dit . . .* (She Told Me). It is a moving true story about his patient Julie, who developed breast cancer, and her journey through the processes of the disease. The cover's subtitle *Cancer du corps, cancer du coeur* (Cancer of the Body, Cancer of the Heart) is a poetic summary of the book's content. He is well published in medical reviews and is past president of an association for the development of the study of geriatric cancer.

Family medicine is not alone in the

world. It is most comforting to see how Dr Delfieu faces the same issues, stresses, and successes that we do . . . albeit in another tongue and culture. The need for our services and compassion is limitless. So all generalists and family physicians of the world are obligated to ensure that we are available and willing to serve now and in future generations.

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Erratum

In the article entitled "Firearm Injury Risk Among Primary Care Patients" (Goldberg BW, von Borstel ER, Dennis LK, Wall E. *Firearm injury risk among primary care patients. J Fam Pract* 1995; 41:158-62), two percentages were inaccurately reported in the abstract: the percentage of homes containing both children and firearms in which at least one gun was stored unlocked (47%), and the percentage of these homes that contained at least one loaded firearm (26%). The correct percentages are 45% and 25%, respectively. The *Journal* regrets this error.

Manuscript Submission

to

The Journal of Family Practice

Submit Manuscripts to the Editor

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