LETTERS TO THE EDITOR

FAMILY INVOLVEMENT IN ROUTINE HEALTH CARE

To the Editor:

It appears that Family Medicine research has arrived: if you do not publish your work in a timely manner, you risk being scooped by someone else! That happened to us with Richard Botelho and associates' paper on family members and friends who come with patients to the family practice clinic.1 We did a similar survey in 1991 and presented the results in a poster session at the 1991 WONCA meeting² but had not yet finished the process by submitting the work for publication. Darn! We can, however, confirm some of Botelho and colleagues' results and shed light on the question of generalizability that they raised.

We, too, surveyed patients in the waiting room, but we did it during two 2-week periods: one in the summer and the other in the winter, to control for seasonality in presenting problems and for schools breaks or summer vacations. Like Botelho et al, we did the study in an urban, academic family practice center, but we also included a suburban, private family practice office to control for differences in patient populations between private and residency practices. Our survey form gathered information similar to Dr Botelho's.

Our total sample was 612 patients, with 203 in the private clinic and 409 in the academic clinic. The private and academic patients did not differ in age, sex, or marital status, but more of the private patients lived with family members (84% vs 73%, respective-

ly) and always had someone with them (47% vs 29%). More of the private patients visited for acute illnesses (52% vs 33%), but fewer of them visited for chronic illnesses (5% vs 11%) and wellness checkup (16% vs 25%).

One half (50% or 102) of the private clinic patients had someone with them, while approximately one third (34% or 138) of the academic clinic patients had a companion with them. The individuals accompanying the private patients, as compared with the academic clinic patients, were more often parents (40% vs 25%, respectively), grandparents (4% vs 0%), siblings (11% vs 6%), and less often spouses (7% vs 23%) and health workers (0% vs 5%). Most of the companions in both clinics provided transportation (29% vs 28%), but many were present for other reasons: some had questions (18%), some helped with following directions (17% vs 13%), and some provided emotional support (15%). For the private patients, more often the companion decided to come with the patient (57% vs 29%), but for the academic patients, more often the patient asked the person to come (48% vs 62%). For both the private and academic clinics, the companions expected (77% vs 68%) and wanted (73% vs 68%) to be in the examination room for the patient's visit with the physician.

Our results are very similar to those of Dr Botelho et al: 39% of the residency patients in the study of Botelho et al had a friend or family member accompany them to the office, and 39% of our private and academic patients had someone with

them. More of their patients had a spouse (40% vs 18% of our patients) or friend (27% vs 10%) with them, and fewer of their patients had a child with them (14% vs 28%). The presence of the companions in the examination rooms was remarkably similar for their residency practice (67%) and our private (77%) and academic (68%) practices.

We agree fully with the issues raised by Dr Botelho et al in the introduction and discussion of their paper. In fact, we are delighted that they put in the effort to summarize the pertinent work in this area. We are also glad to do our part to help clarify the issue of generalizabilty of their results: our two studies together indicate that there may be differences between practices on the types of visits for which patients are seen and who accompanies the patients, but regardless of clinic type, a substantial proportion of patients will have someone with them in the waiting room, and the companion will expect to be in the examination room with the patient for the physician visit.

We regret that we did not win the race to be the first with the science—not really—but it is gratifying to see that research in Family Medicine is moving along. As the saying goes: "It doesn't matter if you're on the right track, you'll still get run over if you don't keep moving."

John C. Rogers, MD, MPH Baylor College of Medicine Houston, Texas

Richard L. Holloway, PhD Medical College of Wisconsin Milwaukee, Wisconsin

REFERENCES

- Botelho RJ, Lue B-H, Fiscella K. Family involvement in routine health care: a survey of patients' behaviors and preferences. J Fam Pract 1996; 42:572-6.
- Rogers J, Holloway R. Family escorts of clinic patients. Poster presented at the World Conference on Family Medicine of the World Organization of National Colleges, Academies and

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, MSPH, Editor, The Journal of Family Practice, 1650 Pierce St, Denver, CO 80214. Telephone (303) 202-1543, Fax (303) 202-1539, E-mail nuttingp@usa.net

Academic Associations of General Practitioners/ Family Physicians. Vancouver, BC, Canada, May 1992.

WARM STETHOSCOPE

To the Editor:

In the September issue of The Journal of Familiy Practice, I read the article by Woo and Danziger on the stethoscope with unusual interest '(Woo Y, Danziger RS. Some also rans' in the evolution of the modern stethoscope. J Fam Pract 1996;43:218-20). I, too, have a patent relating to the modern stethoscope. Like the Swinyar patent, it warms the stethoscope's diaphragm, and since it utilizes a warm pack, it is portable. It's great for morning hospital rounds, all day in the office, and it is still warm for evening visits in the nursing home. For 12 hours it maintains a temperature of 104°. Patients love it, and they love their physicians who care enough to warm cold steel and plastic before placing it on their chest, back, and abdomen.

> Raymond O. West, MD, MPH Belfair, Washington

CORRECTION

In Tips From Practice, the contribution by David Govaker, MD, entitled "Low MCV Anemia" (J Fam Pract 1996; 43:307) contained errors in the representation of Mentzer's formula and the discriminant function. These should have appeared as shown below:

Mentzer's formula:

>14= iron deficiency <12=thalassemia 12-14=indeterminate

Discrminant function:

 $(5 \times \text{Hb})\text{-MCV-RBC-2}= \begin{cases} >0 = \text{iron deficiency} \\ <0 = \text{thalassemia} \end{cases}$

CORRECTION

In the September issue of the Journal, there were some errors in Paula L. Roussel's article, "Impact of CLIA on Physician Office Laboratories in Rural Washington State" (J Fam Pract 1996; 43:249-54). In Figures 1 and 2, the black bars should have indicated "waived status" and the gray bars should have indicated "moderate complexity." These were reversed in the two figures. The text, however, is correct.

Also, in the affiliation line, the date the article was presented to the faculty and residents of Tacoma Family Medicine was June 1995, not 1993.

The author has returned to the United States and can be reached at the following address: Paula L. Roussel, MD, 219 Tacoma Ave North, Apt 401, Tacoma, WA 98403.

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Solution to crossword puzzle on pages 122-123.