

## BOOK REVIEWS

**Working with Asian Americans: A Guide for Clinicians.** Evelyn Lee, editor. Guilford Press, New York, NY, 1997, 504 pp. ISBN: 1-57230-244-5. \$46.95.

*Working with Asian Americans* is a dense book, organized in a manner that makes it a useful reference for family physicians who work with Asian immigrants and refugees. Although the subtitle targets clinicians, much of the information is for mental health professionals, and there are many chapters useful to family physicians.

The book is organized into five sections. The first chapter is an overview, with practical information, including demographics of the Asian American immigrant groups, common characteristics of Asian families, a discussion of the issues of families in varying stages of acculturation, manifestations of psychopathology, help-seeking patterns, assessment guidelines, and psychotherapeutic treatment recommendations. The rest of the first section then devotes a chapter to the unique characteristics and history of each of the following Asian immigrant groups: Cambodian, Chinese, East Indian, Filipino, Japanese, Korean, Laotian, and Vietnamese.

The second section, which discusses the development and life-cycle issues of Asian immigrant children, adolescents, young adults, and elderly, is helpful background material. An example: There is no developmental stage comparable to American adolescence in Asian cultural values; the value of the individual is never more important than the family or the collective.

Section three discusses the therapeutic issues of working with the DSM-IV diagnoses of schizophrenia, depression, post-traumatic stress, substance abuse, and anxiety disorders.

Although the therapeutic detail of this section is more appropriate for mental health professionals, the information can be useful for family physicians. The case examples and discussions remind physicians of the physical trauma (head injury and fractures), starvation, and potential disease exposure (tuberculosis, malaria, parasites, and hepatitis B) in post-traumatic stress disorder patients. The higher incidence of somatization among Asian Americans, compared with European Americans, is explained. The nuances of uncovering substance abuse or post-traumatic stress symptomatology are discussed.

The differences in psychotherapeutic testing and treatment modalities for Asians in section four of the book are most useful to mental health professionals. A practical chapter for family physicians reviews the literature on psychotropic medications and the pharmacodynamic factors unique to Asians. To date, studies show that Asians are slower metabolizers and require smaller doses of neuroleptics, lithium, and benzodiazepines. The authors also remind clinicians of Asians' frequent concurrent use of traditional herbs that can interact with psychotropic drugs. In addition, the importance of carefully explaining side-effect symptoms, the lack of immediate therapeutic effects, and the need for maintenance therapy is considered.

The final section deals with special topics, including homosexuality, women, domestic violence, intermarriage, Buddhism, mental health care delivery, and cross-cultural communication.

This is a well-written, useful reference for physicians who care for Asian American immigrants, and informative reading for those interested in cross-cultural issues.

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**Community-Based Teaching: A Guide to Developing Education Programs for Medical Students and Residents in the Practitioner's Office.** Susan L. Deutsch, editor, and John Noble, associate editor. American College of Physicians, Philadelphia, Pa, 1997, 284 pp. ISBN 0-943126-59-2. \$34.00.

Dr Deutsch and the many authors who contributed to this work have made a significant contribution to those of us charged with the awesome responsibility of the outpatient education of young physicians. Starting with a brief overview of the history of medical education, followed by some thoughts on the barriers to community-based education and teaching, the book addresses opportunities in outpatient learning and outpatient medicine that are not found in large inpatient medical centers. Addressing such issues as longitudinal care, uncertainty management, hospitalization, consultative medicine, and telephone management, the authors touch on real-life medical applications to which students and residents ought to have early and thorough exposure. Chapters and tables dealing with preceptor recruitment and benefits, as well as faculty development and course design, are more summary but provide excellent fodder for the thought process of program design. Many of the tables, however, such as "Preparing for a Student in the Office: Tips for the Preceptor," are extremely thorough and practical.

The authors provide detailed "age-specific" goals and expectations for all levels of training, from first-year medical student through second- and third-year resident. These could be a great help to community preceptors.

The appendices, which include

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information resources, applications, program documentation, and affiliation agreements are quite valuable and informative.

This book will be a welcome addition to the library of community-based educators, especially first-time preceptors, as well as those who shoulder the responsibility of developing community-based programs for medical education.

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**SOFTWARE REVIEW**

**PGP for Personal Privacy, version 5.5.** Network Associates, Inc, 2805 Bowers Ave, Santa Clara, CA 95051; (408) 988-3832.

PRICE: \$39.00

DOCUMENTATION: Printed manual with CD-ROM. 111-page Adobe Acrobat file. Windows Help file.

HOW SUPPLIED: CD-ROM

HARDWARE & SOFTWARE REQUIREMENTS: Windows 95/NT, 9.4MB hard disk space. Versions available for UNIX and Macintosh.

CUSTOMER SUPPORT: (408) 988-3832

DEMONSTRATION DISK: Download from <http://www.pgp.com>. Free for non-commercial use. Full-featured; some limits in backward compatibility.

RATING: Two thumbs up. Makes strong encryption widely accessible.

In the mid-1980s I helped establish a medical school's E-mail system. One night, I noticed an unfamiliar routine running and, on investigation, found an outside consultant scrolling through our E-mail. When confronted, he stopped this practice. However, most of our system's users never learned of this—and most E-mail users today would be just as unaware if this were to happen to them. A solution to such problems appeared in the mid-1990s with the development of software that allows messages to be encrypted for transmission. An example of a message encrypted by one such program, *Pretty Good Privacy (PGP)*, is depicted in Figure 1.

Why should this be of interest to family physicians? Patients are becoming more computer literate and are searching the Internet for health information. Some patients and physicians are already using it for communication, including transmittal of potentially sensitive infor-

mation. This is a logical extension of traditional mail service, answering machines, and other common methods of physician-patient communication. Because of the advantages of electronic communication, including timeliness, ease of use, and efficiency, odds are that such correspondence will increase. Obviously, one major concern when communicating medical information is security.

In truth, unencrypted (plain text) E-mail is much like a simple postcard. It resides on a computer as a file like any other file, usually relatively easy to display. Anyone who finds it can access the contents without expending effort to "steam it open." When the E-mail is transmitted via the Internet, it hops from computer to computer along the route. At any of these stops, someone may choose to read other people's messages. A hospital, university, or other corporate E-mail facility may seem more secure, but the law grants no guarantee of privacy to a worker using company hardware. Because of these confidentiality issues, the American Medical Informatics Association's Internet Working Group has produced a set of Guidelines for the Clinical Use of

FIGURE 1

In the foreground, PGP tools on a Macintosh. The E-mail message is composed in the usual fashion. Then, by using the PGP "Encrypt and Sign" function, the encoded E-mail in the background is produced, ready for secure transmitting.

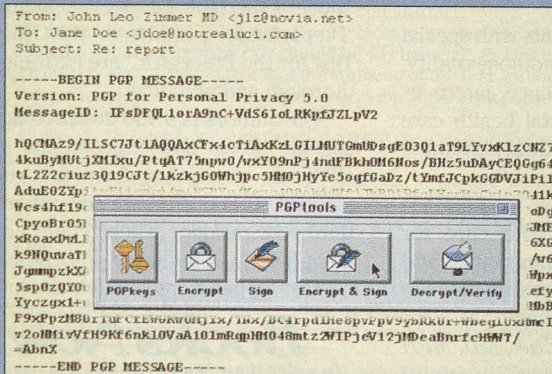
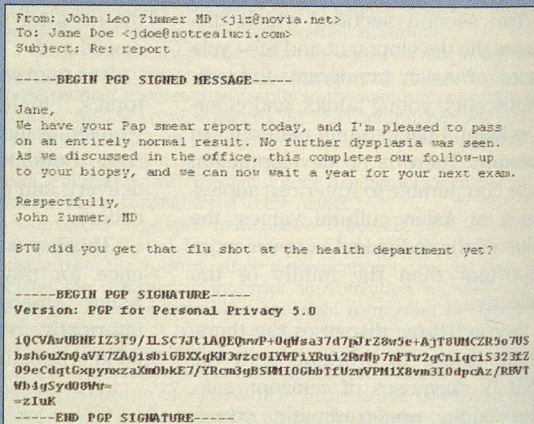


FIGURE 2

The message in Figure 1 as it appears when decrypted by the recipient, with an attached PGP signature to verify its origin and integrity.



Electronic Mail with Patients.<sup>1</sup> They suggest encryption of all E-mail going to patients. They suggest that the alternative — corresponding without such protection — should require prior informed consent.

The result of a cervical cytology is the type of report that a physician might send to a patient by telephone but not (without prior agreement) to an answering machine or to another member of her household. Most physicians would consider a sealed letter appropriate, but not a postcard. Similarly, encryption allows the protection of sensitive information within a digital envelope. Depending on the quality of the encryption applied, the contents are rendered unreadable to casual and, if properly implemented, even determined attack. Not all encryption software is created equal. Highly specialized expertise is required to evaluate the true strength of such software. *PGP* is considered "strong encryption" in the technical sense

used by cryptographers to describe highly secure mathematical encryption algorithms.

Let me illustrate use of *PGP* to send a laboratory result to my patient Jane. I would first compose the message in my E-mail package. (Eudora Pro, a type of popular Windows E-mail software, works very nicely with *PGP*.) To encrypt the message to Jane, I use *PGP* and Jane's "public key," which she has previously provided to me. I send the encrypted E-mail in the same fashion as any other E-mail. Rather than traveling through the Internet as plain text, it travels as encrypted text. Jane receives it in the same encrypted fashion that I sent it. She then uses *PGP* and her "private key" to unencrypt my message. Note that *PGP* uses Jane's public key to encrypt a message that only her private key can decode. Figure 2 has the same content rendered accessible only to Jane.

The signature in Figure 2 was

produced using the physician's private key. It can be verified by anyone who has his public key. The "signature" is an authentication code added to a file or message, which anyone can use to confirm that the information remained unaltered during transit and truly originated from the purported author. Use of the signature also serves to indicate the sender's ability to employ the *PGP* software.

*PGP* is a good starting point for computer users concerned with the security of on-line information transmission or who simply want to learn more about secure transmission.

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#### REFERENCES

1. Kane B, Sands DZ. Guidelines for the clinical use of electronic mail with patients. *J Am Med Info Assoc* 1998; 5:104-11.

#### Correction

An error in a figure legend appeared in an article published in the August issue (*Gross DA, Zyzanski SJ, Borawski EA, Cebul RD, Stange KS. Patient satisfaction with time spent with their physician. J Fam Pract* 1998; 47:133-7). The figure should have shown that patient satisfaction with time spent with their physician is highest for longer visits involving evaluation feedback. The solid black line and the dotted black line in the figure legend should be reversed.