

# 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.

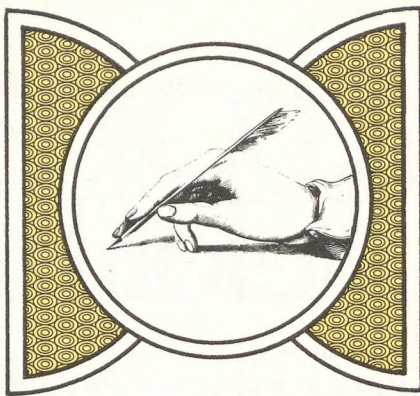
## Outcomes of Acute Care

To the Editor:

Any attempt to measure quality of care is to be applauded, but a recent paper by Kane RL et al (*Differences in the outcomes of acute episodes of care provided by various types of family practitioners. J Fam Pract 6:133, 1978*) cannot be allowed to pass without comment. The results of their study imply differences between providers in terms of outcome and patient satisfaction. We have a number of misgivings about the validity of these results, and these doubts are particularly related to the lack of evidence of standardization in the methods described.

We would like to pose the following questions.

1. The paper refers to a prior publication (Kane RL et al: *A method for assessing the outcome of acute primary care. J Fam Pract 4:1119, 1977*), which indicated that age and sex had no effect on measurements of outcome in acute care. Are we to assume that this was also true for the symptoms and diagnoses in the latest study? Did providers see patients from similar age groups, and with similar sex distribution?



2. The methods described made no reference to socioeconomic status of patients. Do the authors consider that this factor has no effect on outcome and patient satisfaction? Was the range of patients from varying socioeconomic groups similar for different providers of care?

3. Is the inclusion of only two physician's assistants acceptable when comparing the activities of a range of primary care providers? We believe that this very small sample of physician's assistants invalidates a number of the conclusions rendered.

4. Was any staging process used in identifying patients with similar problems? For example, it may be reasonable to suggest that the outcome would be different in a patient who presents with a headache of 24 hours duration, as opposed to a headache of one week's duration.

5. The authors indicate that patients with chronic problems were excluded from the study. Nevertheless, many patients with acute symptoms and illnesses will have associated problems of physi-

Continued on page 268

# SINGLE-ENTITY CHOLEDYL® (OXTRIPHYLLINE)

**CAUTION:** Federal law prohibits dispensing without prescription.

**Description.** Each partially enteric coated tablet contains 200 mg or 100 mg oxtriphylline. **NOTE:** 100 mg oxtriphylline is equivalent to 64 mg anhydrous theophylline.

**Indications.** Cholelyl (oxtriphylline) is indicated for relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

**Warning.** Use in pregnancy—animal studies revealed no evidence of teratogenic potential. Safety in human pregnancy has not been established; use during lactation or in patients who are or who may become pregnant requires that the potential benefits of the drug be weighed against its possible hazards to the mother and child.

**Precautions.** Concurrent use of other xanthine-containing preparations may lead to adverse reactions, particularly CNS stimulation in children.

**Adverse Reactions.** Gastric distress and, occasionally, palpitation and CNS stimulation have been reported.

**Dosage.** Average adult dosage: Tablets—200 mg, 4 times a day.

*Dosage should be individualized.*

**Supplied.** 200 mg, yellow, partially enteric coated tablets in bottles of 100 (N 0047-0211-51) and 1000 (N 0047-0211-60); Unit Dose—10 x 10 strips (N 0047-0211-11); 100 mg red, partially enteric coated tablets in bottles of 100 (N 0047-0210-51). **STORE BETWEEN 59° and 86°F (15° and 30°C).**

**Toxicity.** Oxtriphylline, aminophylline and caffeine appear to be more toxic to newborn than to adult rats. No teratogenic effects have been seen.

Full information is available on request.



**WARNER/CHILCOTT**  
Division, Warner-Lambert Company  
Morris Plains, New Jersey 07950

# Fastin® 30 mg. (phentermine HCl)

Before prescribing FASTIN® (phentermine HCl), please consult Complete Product Information, a summary of which follows:

**INDICATION:** FASTIN is indicated in the management of exogenous obesity as a short-term (a few weeks) adjunct in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

**CONTRAINDICATIONS:** Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate-to-severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma.

Agitated states.  
Patients with a history of drug abuse.  
During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

**WARNINGS:** Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued.

FASTIN may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

**Drug Dependence:** FASTIN is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of FASTIN should be kept in mind when evaluating the desirability of including a drug as part of weight-reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia.

**Usage in Pregnancy:** Safe use in pregnancy has not been established. Use of FASTIN by women who are or who may become pregnant, and those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and infant.

**Usage in Children:** FASTIN is not recommended for use in children under 12 years of age.

**PRECAUTIONS:** Caution is to be exercised in prescribing FASTIN for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of FASTIN and the concomitant dietary regimen.

FASTIN may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

**ADVERSE REACTIONS:** *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure. *Central Nervous System:* Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely psychotic episodes at recommended doses. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria. *Endocrine:* Impotence, changes in libido.

**DOSAGE AND ADMINISTRATION:** *Exogenous Obesity:* One capsule at approximately 2 hours after breakfast for appetite control. Late evening medication should be avoided because of the possibility of resulting insomnia.

Administration of one capsule (30 mg) daily has been found to be adequate in depression of the appetite for twelve to fourteen hours. FASTIN is not recommended for use in children under 12 years of age.

**OVERDOSAGE:** Manifestations of acute overdosage with phentermine include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension, and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

Management of acute phentermine intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard. Acidification of the urine increases phentermine excretion. Intravenous phentolamine (REGITINE) has been suggested for possible acute, severe hypertension, if this complicates phentermine overdose.

**CAUTION:** Federal law prohibits dispensing without prescription.

**Beecham**  
laboratories  
Bristol, Tennessee 37620

## LETTERS TO THE EDITOR

Continued from page 264

cal, psychological, and social origin. How many patients in the study had associated problems and, if these factors were included, what effect did they have on outcome?

We do not wish to appear carping in our criticism, but we firmly believe that rigorous attention to detail is necessary when attempting to measure quality of care.

D. J. G. Bain, MD

W. J. Coggins, MD

Department of Community Health  
and Family Medicine  
University of Florida  
College of Medicine  
Gainesville, Florida

*The preceding letter was referred to Dr. Kane who responds as follows:*

Drs. Bain and Coggins raise a number of very pertinent questions about any study which would purport to measure the quality of care. There is growing recognition that this type of activity is particularly difficult in the primary care arena where the spectrum of services is wide. I would like to take this opportunity to respond to some of their questions in the order that they raised them.

1. The earlier paper emanating from the same study that prompted their letter was intended to provide some background data about the methods used in the outcome assessment technique. The data reported there on the lack of any effect of age and sex on measures of outcome would therefore apply directly to this study since it is the same data. It should be underlined that the population covered by the

particular family practice clinics in which this study was based had a relatively narrow age range: only six percent of the patients were over the age of 50; 60 percent were female. There were no significant differences in the age or sex distributions of the patients seen by various provider types.

2. The omission of socioeconomic status from our description of the patients was not based on a lack of concern about its potential effects on either outcome or satisfaction. Unfortunately, no measures of this variable were included in the study instrument and there was no way of identifying socioeconomic status from the clinic charts. The general perception of the providers of care suggested that there was no discrimination among the various providers along the dimensions of socioeconomics, status, age, or sex.

3. It would have been highly desirable to involve more than two physician's assistants in the study. Unfortunately, this represented the universe of those available. Several well-done studies have shown very similar results with equally small sample sizes. Taken as a total group, the growing body of literature on the performance of physician's assistants and nurse practitioners would suggest that the quality of care provided is equivalent to that of physicians, at least for those problems with which the PA and NP deal.

4. No specific staging process was used to reclassify diagnostic groups to more specific clusters. One of the major problems was the lack of adequate sample size. Given the heterogeneity of problems presenting at the clinics, we had difficulty in defining suffi-

Continued on page 270

Continued from page 268

ciently large groups of patients with the same diagnosis to compare outcomes. We did, however, try to control for potential variables in our analysis. For example, Table 1 in the paper, although badly mislabeled typographically, controlled for the presenting functional status. We have in other analyses not presented in this paper looked at the accuracy of physician predictions about the outcomes of their patients. This, in essence, represents a staging of each case by the physician. When we did this, we noted that physicians could correctly predict the cases with good outcomes at better than 95 percent; however, the predictions of the cases of the poor outcomes were in the range of less than 15 percent. The PA accuracy of prediction fell between those of the various providers.

5. Many of the same points can be raised in terms of the questions about the presence of chronic illness. Chronically ill patients represented only a small minority of the overall patients seen. If one looks at the larger question of how many patients had associated problems, then the potential number of patients included becomes much larger. The clinic utilized the problem-oriented record system which encouraged the providers to note as complete a set of problems as possible. We did not utilize this data in our analysis, however. To the extent that the providers felt that these factors were important in terms of their effect on outcome, they would have been included in the provider's prognosis. As we have already noted, that prognosis tended to underestimate the individuals with bad outcomes.

The comments of Drs. Bain and

Coggins are important in underlining the need for careful replication of studies like this one. This effort represents our second such study, with some minor modifications, particularly in regard to the follow-up technique used. The results were generally consistent between the two studies. The results were also consistent with basically similar approaches used in a study of private practice (JAMA 236: 2509, 1976). We would hope that others in family practice might be stimulated to undertake similar studies of the outcomes of primary care. We are especially anxious that someone identify a feasible means of tracking the outcomes of that large body of primary care activity which generally falls under the rubric of health maintenance.

Robert L. Kane, MD  
The Rand Corporation  
Santa Monica, California

## Cognitive Skills and Clinical Performance

To the Editor:

I am deeply troubled by one hypothesis and one result stated in Dr. Parkerson's paper, Labstand: A Computerized System for Reporting Clinical Laboratory Data in Standard Units, in your March issue (*J Fam Pract* 6:611, 1978).

The assumption is made that "Board scores are indicative of cognitive skills related to management of medical problems." Unfortunately, National Board scores

Continued on page 274

## Tablets

# Percodan® II

**DESCRIPTION** Each yellow, scored tablet contains 4.50 mg. oxycodone HCl (WARNING: May be habit forming), 0.38 mg. oxycodone terephthalate (WARNING: May be habit forming), 224 mg. aspirin, 160 mg. phenacetin, and 32 mg. caffeine.

**INDICATIONS** For the relief of moderate to moderately severe pain.

**CONTRAINDICATIONS** Hypersensitivity to oxycodone, aspirin, phenacetin or caffeine.

**WARNINGS Drug Dependence** Oxycodone can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence and tolerance may develop upon repeated administration of PERCODAN®, and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral narcotic-containing medications. Like other narcotic-containing medications, PERCODAN® is subject to the Federal Controlled Substances Act.

**Usage in ambulatory patients** Oxycodone may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using PERCODAN® should be cautioned accordingly.

**Interaction with other central nervous system depressants** Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with PERCODAN® may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

**Usage in pregnancy** Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, PERCODAN® should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

**Usage in children** PERCODAN® should not be administered to children.

Salicylates should be used with caution in the presence of peptic ulcer or coagulation abnormalities.

**PRECAUTIONS Head injury and increased intracranial pressure** The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

**Acute abdominal conditions** The administration of PERCODAN® or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

**Special risk patients** PERCODAN® should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Phenacetin has been reported to damage the kidneys when taken in excessive amounts for a long time.

**ADVERSE REACTIONS** The most frequently observed adverse reactions include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down.

Other adverse reactions include euphoria, dysphoria, constipation and pruritus.

**DOSAGE AND ADMINISTRATION** Dosage should be adjusted according to the severity of the pain and the response of the patient. The usual adult dose is one tablet every 6 hours as needed for pain.

**DRUG INTERACTIONS** The CNS depressant effects of PERCODAN® may be additive with that of other CNS depressants. See WARNINGS.

DEA Order Form Required.

## Endo Inc.

Manati, Puerto Rico 00701  
Subsidiary of Endo Laboratories, Inc.  
Subsidiary of the DuPont Company



Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation; increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants: causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. *Geriatric patients:* 5 mg b.i.d. to q.i.d. (See Precautions.)

**Supplied:** Librium<sup>®</sup> (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose<sup>®</sup> packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50, available singly and in trays of 10. Libritabs<sup>®</sup> (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

## LETTERS TO THE EDITOR

Continued from page 270

only test memory, and memory, particularly for complex information, is notoriously volatile. The physician I wish for my family (and the archetypal best physician I urge residents to emulate) is that physician who is thorough, reliable, efficient, and displays analytic sense independent of memory. If this physician does not know a fact with certainty, he or she looks the information up.

In this context, the most disturbing aspect of this paper was the documentation of the failure to recognize no less than 57.8 percent or 583 of 1,008 abnormal results. This profound indictment of our performance when dealing with real people deserves sober reflection. Moreover, this level of performance is far from what we should strive to teach as the model for nascent family physicians.

Douglas H. McNeill, MD  
Associate Director  
Waukesha Family Practice  
Center  
University of Wisconsin  
Waukesha, Wisconsin

## Psychologists in Family Medicine

To the Editor:

I would like to inform you of the following information in the hope that it may be of some value to you and to the readers of *The Journal of Family Practice*. There is, currently in the process of rapid development, an organization of *Psychologists in Family Medicine*. PFM is a growing group of psy-

chologists working in family medicine settings—departments of family practice, family medicine residency programs, or with family physicians in private practice. The purpose of the group is to serve as a forum for the exchange of ideas, information, problems, etc. The organization publishes a *Newsletter*. The *Newsletter* is actively soliciting contributions which may be mailed to: Arnold T. Shienvold, PhD, Editor, Psychologists in Family Medicine Newsletter, Department of Family Practice, Harrisburg Hospital, Harrisburg, PA 17101.

Since August 1977, there have been a variety of regional organizational meetings which will culminate in a major organizational session at the 1978 National Convention of the American Psychological Association in Toronto, in August 1978. Additionally, at the APA Convention there will be a symposium consisting of several papers addressing the topic of "Contemporary Issues in Teaching Psychology to Family Practice Residents."

Let me finally add that PFM is also involved with the Medical Psychology Network which is a group of several hundred psychologists involved in various medical settings seeking to organize the field of medical psychology. Further information about the organization may be gained by writing to: Michael J. Asken, PhD, Director, Behavioral Sciences and Medical Psychology, Department of Family Practice, Polyclinic Medical Center, Harrisburg, PA 17105.

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