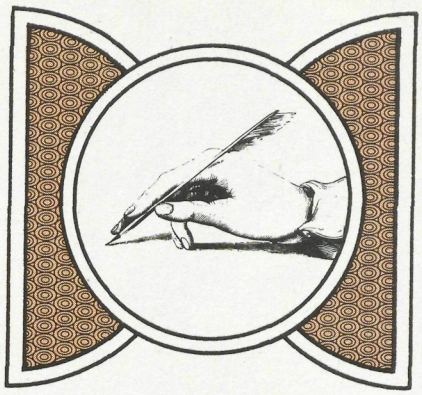
Letters to the Editor



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.

Care of Hypochondriacal and Resistive Patients

To the Editor:

I am writing to express some reactions to the article, "Hypochondriacal and/or Resistive Patients" *(Authier J, Long WB, Clemens D, et al. J Fam Pract 8: 839, 1979)*.

Let me begin by wondering why so little attention is paid to the use of psychotropic medications in the situations presented. Though some caveats are proposed, the general tone is one of acceptance of the general use of these drugs. Thus, ". . . a 31-year-old white female . . . with a history of withdrawal, depression, and suicide attempts, resulting in lengthy hospitalizations . . ." is given chlordiazepoxide and diazepam, presumably over a long period of time. Further, ". . . a 27-year-old white male [who] has a past history of abuse of Darvon and other analgesics . . ." and who gives the impression of being ". . . a tranquilizer abuser . . ." is given an antihistamine and Doxepin, on separate occasions. It is difficult indeed to discern any rational principles of drug prescribing in these episodes.

I believe that it is insufficient justification to say that "We are in the business to 'relieve pain and suffering'," particularly because such a rationalization avoids the question of the origins of emotional pain and the likelihood that significant personal development often requires painful impeti. It is especially important in family practice that we challenge the notion that we can buy continued visits and 'compliance' through our early prescribing of medications. This is a common assumption and a rationalization used to justify the giving of psychotropic medications, yet I know of no evidence that justifies it.

The second matter is that almost overwhelming urge we have as physicians and health care professionals to label our patients or clients. Thus we end up with hypochondriacal, hysterical, passive-aggressive, passive-dependent, resistive, and hostile/angry patients, when what is likely closer to the truth is that we have a terrible time dealing with those patients because of the feelings *we* experience in response to them and the difficulty we have in separating their functions from our own.

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The point is that though labels can be of considerable value in making prognoses and in striking management plans, they can also be pejorative and damaging to the helper/client relationship. It is a matter of particular concern to me that this article leaves the impression that there is a consistent management plan available, once such labels can be applied, when my experience tells me clearly that the development of a caring and therapeutic relationship in such situations requires all of the skill and creativity that I can muster.

Family medicine teaching must give as imperatives the need to understand—with all of the resources of knowledge and personality at our disposal—the origins of patients' pains, and the importance of using the bond of our relationship with those patients to reach mutual conclusions regarding the "label" and appropriate responses to it. The complexities of practice cannot be reduced through the use of medications and standardized protocols.

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The preceding letter was referred to Drs. Authier and Long who respond as follows:

We would like to compliment Dr. Newell for various points that he makes regarding the recent article, "Hypochondriacal and/or Resistive Patients," by Authier J, Long WB, Clemens D, et al (*J Fam Pract 8:839, 1979*), since we do not see ourselves in disagreement with him in a general sense. Indeed, his responses appear valid to us based on the fact that perhaps our article did not sufficiently convey that our Rounds was being presented to a group of family practice residents. If we were speaking to physicians in practice our expectations would be higher, our labeling of patients may have been different, and we certainly would have been discouraging the overuse of psychotropic medications.

Dr. Newell wondered why so little attention was paid to the use of psychotropic medications in the case examples. We do pay a significant amount of attention to the use of psychotropic drugs in our training program, but perhaps our article did not make this sufficiently clear. In essence, we are stating that in our experience residents, especially new residents, have a tendency to underutilize psychotropic medications. As a result, we attempt to give residents considerable latitude in the prescribing of medications, so they can learn within a structured framework the appropriateness of prescribing psychotropic drugs. Specifically, the second patient, the 27-year-old white male who had been a tranquilizer abuser, was given antihistamines as a hypnotic because of his abuse history, and Doxepin was used not only as an antidepressant but as an antianxiety agent, again because of his abuse history and the fact that both of these medications are non-

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habituating and nonaddictive.

Dr. Newell's second point of there being insufficient justification to say that we are in the business to "relieve pain and suffering" is taken out of context because it does not completely portray the intention of that particular statement. The intent was one of helping residents overcome their overreaction to prescribing psychotropic drugs since they have been imbued with the knowledge that older physicians overutilize said medications. In the process, of course, a number of patients are denied significant benefits of psychotropic medications on a short-term basis.

We appreciate that labeling patients can often have a "pejorative and damaging" impact on the physician-patient relationship but are hopeful that in our training setting we are successful in teaching the main purpose of labels, ie, a professional shorthand rather than a labeling for labeling's sake. Moreover, we are hopeful that the labels are helpful in setting general management plans but certainly did not intend to convey that a consistent management plan is always possible as a result of the label. We appreciate Dr. Newell's point that often patients which physicians find difficult to manage are more of a result of the physicians' own feelings in response to these kinds of patients, rather than specifically a problem with the patient. The published Rounds did not provide an in-depth emphasis on self-awareness, an area which we feel is a very important aspect of successfully managing the "hypochondriacal" and/or resistive patient. However, self-awareness is emphasized during other portions of our training program.

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Hospital Practice of the Family Physician

To the Editor:

The recent editorial in the May issue of *The Journal of Family Practice* entitled "Hospital Practice of the Family Physician" *(Geyman JP: J Fam Pract 8:911, 1979)*, is an appropriate and timely article reviewing the present status of the family physician in the hospital setting. While retrospective and cross-sectional studies document what family physicians do in urban and rural hospitals, the key element for critical discussion relates to the comparison of family physicians with other specialists in the care of hospitalized patients. It was unfortunate that your editorial referred to an as yet unpublished report from Garg NL et al as a basis for this critical element. Fundamental questions in this area can be elucidated through carefully controlled prospective studies of recent graduates in approved residencies in

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both family practice and general internal medicine. I look forward to future studies comparing the quality of hospital care provided by family physicians with that provided by other specialists.

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Indications for CT Scanning

To the Editor:

At the Second Annual Meeting of the Society for Computerized Tomography and Neuro-Imaging held at Hilton Head Island, South Carolina, October 29, 1978, the subject of contrast enhancement in CT Scanning was discussed. The generally agreed upon indications for the use of intravenous contrast to help delineate lesions of the brain are as follows:

1. Previously treated brain tumors
2. Abnormal Isotope Scans, cerebral arteriograms, or other positive neurodiagnostic tests
3. Possible posterior fossa lesions, especially cerebellar pontine angle tumor
4. Metastatic disease
5. Arteriovenous malformations or aneurysms
6. Patients with focal central nervous system signs
7. Sellar and parasellar lesions

An excess of enhancements in CT Scans are being done throughout this country routinely. Contrast enhancement can lead to reactions in five percent of patients and mortality in anywhere from 1 in 30,000 to 50,000 cases. Because of this, contrast should only be given when central nervous system disease is strongly suspected and/or when one of the aforementioned criteria is present. The situations in which contrast enhancement is least productive are congenital lesions, degenerative diseases, infarct, and trauma. Caution should be exercised in patients over 70 years of age, in those with cardiac disease (especially failure), and in any seriously ill patient.

Neurologists and neurosurgeons order fewer contrast enhancement CT Scans than other physicians. This may be because the indications have not been spelled out to the large body of physicians who are ordering these tests.

Computerized tomography is an expensive procedure, and there are times when the physician is forced to order one in spite of the fact that it is very unlikely that a lesion is present, eg, persistent headaches. The routine CT Scan without contrast yields much information. The use of contrast should be carefully considered, and then it should be used only when indications are present. In this way, a remarkable diagnostic procedure without any morbidity or mortality will not become a procedure with the possibility of complications.

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