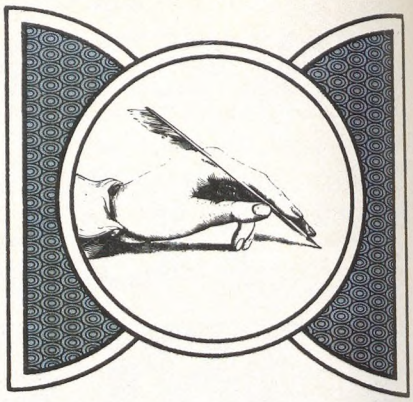
Letters to the Editor



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.

Preventive Medicine in Family Practice

To the Editor:

For the third year, the UCLA Family Practice Group will be measuring physician-trainee compliance with establishing an effective data base and then implementing appropriate preventive medicine strategies. We too have found that, with a modest educational program and a committed faculty, significant changes in physician compliance can occur. Adult medical record reviews in 1979 (n=182) and 1980 (n=189) revealed noted improvement in Pap smear acquisition but continued deficiencies, particularly in adult immunization for tetanus and pneumococcal vaccine. Fewer than 10 percent of eligible adults were noted to be immunized for these two diseases.

In support of the findings by Chu and Day *(J Fam Pract 12:657, 1981)*, we found that our physicians recorded smoking status in only 50.4 percent of the charts reviewed over two years. Alcohol consumption was noted in 47.4 percent. These health risks are not trivial. It is our belief that the medical record can be redesigned to assist in physician compliance with these issues. This design must anticipate future chart review as a quality control measure.

Dr. Mahn and Dr. Sackett have commented on the need for follow-up measures to determine whether such changes in physician or patient behavior remain permanent without further monitoring.[1,2] Just as chart review is a mandatory part of the American Board of Family Practice's recertification process, we urge such activity as a routine ongoing credibility check for preventive medicine teaching in residency training programs.

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2. Sackett DL: Compliance trials and the clinician. Arch Intern Med 138:23, 1978

Drug Samples in a Model Unit

To the Editor:

Recent articles have directed attention to the relationship of the clinical pharmacist to the family physician, either in practice or in residency training.[1-3] These initial assessments underscore a potential educational function for both physicians and patients. In many settings, there is no formal partnership with the clinical pharmacist, and

Continued on page 805

Continued from page 802

drug information may be collected in a less centralized fashion, such as from texts, journals, newsletters, advertising, or pharmaceutical representatives. As sample drugs are often a legacy of a representative's visit, it is not unusual to find a "sample" pharmacy in an office practice. A "sample" pharmacy was created in this manner at the Family Medicine Center of the Deaconess/Buffalo General Hospital and State University of New York at Buffalo, Department of Family Medicine.

The center's policy permits pharmaceutical representatives to visit the office, speak informally with the residents, and leave sample drugs. An average of three separate representatives visit each week. These samples are periodically inventoried to identify outdated items, but no restrictions (other than a prohibition of controlled drugs) are applied. No formal relationship with a clinical pharmacist existed at the center prior to this study.

In December 1980 the available products in the center's sample pharmacy were surveyed, and a total of 185 items was found. Major pharmacologic classes included antiseptics (16 percent), bronchodilators (15 percent), antihypertensives (8 percent), cough and cold preparations (8 percent), potassium supplements (6 percent), oral contraceptives (6 percent), laxatives (4 percent), and dermatologics (5 percent).

All drugs were reviewed by a clinical pharmacist to ascertain their efficacy and appropriateness. Criteria for inappropriate formulations included combinations of drugs in subtherapeutic doses or with agents lacking documented efficacy, dosage forms without therapeutic or cost advantages over generic products, and products containing potentially harmful reactions with little or no therapeutic effects. Nearly one third (31 percent) of the inventory was classified as inappropriate.

Resident physicians at the center are receptive to the idea that these products are made available free of charge. They frequently dispense these products to patients in an effort to defray the cost of the prescription. In addition, these samples are convenient "starter doses," or are useful when Medicaid does not reimburse the prescription.

Potential problems arise in this environment of free samples. Physicians become familiar with certain brand name products that become costly purchases for the consumer. Selection of products based on familiarity without rational pharmaceutical evaluation exposes patients to less than ideal and potentially harmful drug exposure.

We find that the unmonitored sample formulary contains a significant number of inappropriate pharmaceuticals, a fact which may permit the development of suboptimal prescribing patterns. The involvement of the clinical pharmacist in a continuous review of office "sample pharmacies" could minimize their hazards yet preserve their advantages.

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3. Robertson DL, Groh MJ, Papadopolous DA: Family pharmacy and family medicine: A viable private practice alliance. J Fam Pract 11:273, 1980