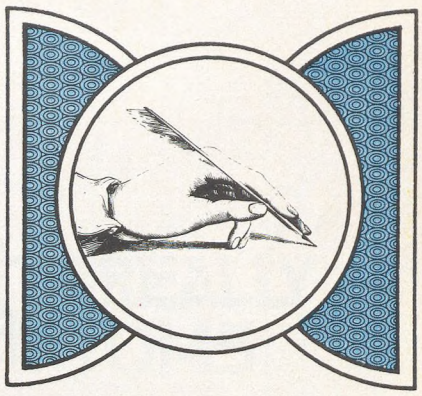
Letters to the Editor



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.

Evaluating Curriculum Effectiveness

To the Editor:

Teachers of family medicine who try to assess the effectiveness of their curriculum often find it impossible to apply rigorously standard evaluation designs such as those described by Campbell and Stanley[1] when faced with the "rumpled reality" of teaching. This communication describes a quick and simple measure we have used to evaluate curriculum effectiveness in order to adjust resources and shift emphasis.

The Section of Family Medicine at Brown University conducts a required six-week clerkship in family medicine and community health for third and fourth year medical students. An oral examination using preestablished criteria[2] is used as part of the final evaluation.

In January 1980 a case study was used that tested the students' knowledge of the diagnosis and treatment of alcoholism. Of the eight students taking the oral examination, only one diagnosed alcoholism as a problem, and none of the eight confronted the patient with the problem.

Because of our concern about the lack of sensitivity to the diagnosis of alcoholism, 5.5 hours of didactic and experiential teaching in alcoholism were incorporated in the clerkship.

The same oral examination case study was repeated in April 1981. All seven of the students taking the oral examination diagnosed alcoholism as the chief problem. Six of the seven students forcefully confronted the patient with his problem drinking. The difference in these two criteria are significantly different as compared to the January 1980 performance based on the nonparametric sign test ($P = 0.016$, one-tailed binomial test for each of the two major criteria).

Based on the results of this quick evaluation, we felt reasonably comfortable concluding that the curriculum intervention was successful. In addition, despite the fairly brief 5.5-hour intervention, it was felt that this might be sufficient.

The advantages of this design are simplicity, quick results, and utility. It allows the curriculum planner to quickly assess whether the intervention has been successful, although this is only one of several explanations for the observed improvement.

The disadvantages of this static group comparison design include the failure to take into account differences between the control and the experimental group, interven-

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ing factors between the two periods of time, nonrandom assignment of individuals to the two groups, and possible bias in the examiners.

In no way does this design substitute for the more rigorous experimental or quasiexperimental reresearch designs. However, the latter are often too cumbersome to use to meet the day-to-day needs of a teacher, and the approach described above should be seriously considered by family medicine educators.

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References

1. Campbell DT, Stanley JC: Experimental and Quasiexperimental Designs for Research. Chicago, Rand McNally, 1972
2. Holcomb JD, Garner AE: Improving Teaching in Medical Schools. Springfield, Illinois, Charles C Thomas, 1973

Simultaneous Influenza and Pneumococcal Vaccination

To the Editor:

In the August issue of this Journal appeared "Adverse Reactions to Simultaneous Influenza and Pneumococcal Vaccination" (*J Fam Pract 13: 175, 1981*) in which the author, Dr. McCue, concluded, "Simultaneous administration of pneumococcal and influenza vaccines consistently caused more side effects than either vaccine alone, although all the differences were quite small."

This study suffers from a complete avoidance of statistical analysis to support the author's conclusion. Furthermore, cursory examination of the results shows additive incidences of side effects by receiving pneumococcal influenza shots on separate visits exceeds that of receiving them together. Here again, statistical analyses should be employed for this only adds further credence to the tenet that both vaccines be given concomitantly.

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The preceding letter was referred to Dr. McCue, who responds as follows:

I agree entirely with Dr. Creager's comments. Statistical data were omitted, since on simple inspection of the data no statistical difference is evident. How important statistical analysis is in a study such as this is, moreover, unclear. Other studies cited in the article support the conclusion that simultaneous vaccination increases the incidence of side effects slightly but probably not significantly. I agree with the conclusion that in most circumstances both vaccines should be given concomitantly.

Jack D. McCue, MD
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Patient Acceptance of Physicians' Assistants

To the Editor:

We were pleased to note continuing documentation of physician assistant patient acceptance in the article "Patient Attitudes toward Physicians' Assistants" (*J Fam Pract 13: 201, 1981*). It was espe-

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cially gratifying to learn that in this study 92 percent of the sample was usually or always satisfied with physicians' assistants' care.

Despite this positive finding, we were concerned with the general negative tone that permeates the article. We were particularly troubled by the implication that the use of a physician's assistant invites some inevitable discomfort for patients. Research on the quality of care provided by physicians' assistants and nurse practitioners in an ambulatory setting when a physician is present has been found to be equal to that provided by fully trained physicians.[1,2]

I hope this article will be carefully read by family physicians so that its positive findings will be apparent. We think it unfortunate that these were not emphasized more in the article.

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W. Ward Patrick, MD
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References

1. Sox HC: Quality of patients care by nurse practitioners and physician's assistants: A ten-year perspective. Ann Intern Med 91:459, 1979
2. Goldberg GA, Jolly DG: Quality of care provided by physician's extenders in Air Force primary medicine clinics. Santa Monica, Calif, Rand Corporation, 1981

The preceding letter was referred to Dr. Smith, who responds as follows:

I feel that it is unfortunate that Mr. Daddabbo and Dr. Patrick feel that the article conveys a negative tone. The central point is that patients are satisfied with physicians' assistants *provided* they are adequately supervised and that the patients are convinced that this supervision exists. While it is clear that there is high acceptance of physicians' assistants, the primary point I wish to make is that this acceptance is more likely to occur within the limitations that are discussed in the article, that is, that the supervision exists and that the physicians' assistants are functioning in a role that the patients interpret as an appropriate role (providing routine functions, health information, and physical examinations as opposed to diagnostic and treatment encounters). There was concern expressed about the implication that the use of physiicans' assistants invites discomfort for patients; however, it should be noted that 29 percent of the patients in the study were at least oc-

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casionally uncomfortable with physicians' assistants or had had unsatisfactory physician's assistant visits. The statement was not intended to imply that there was inevitable discomfort for all patients who see physicians' assistants. The statement was made that research shows the quality of care provided by physicians' assistants is equal to that of fully trained physicians. It should be noted that we did not attempt in this study to look at quality of care, but only at patient satisfaction. Patients are sometimes dissatisfied with the health care encounters, even if the care is of the highest quality.

While it is true that the article reports on high patient acceptance of physicians' assistants, it would be a mistake to leave the data at that point. I would disagree with the statement that controversy, emotional reaction, and confusion surrounding the use of physicians' assistants is not documented in this study. Questions dealing with the issue of uncomfortable visits with physicians' assistants, patients going elsewhere for health care because of seeing physicians' assistants, and frankly negative reactions to physicians' assistants certainly deal with the question of emotional reactions to them. The area of confusion with the use of physicians' assistants is documented in the section of the article reporting on patients' perception of the role in training a physician's assistant. It is clear from the data that many patients are confused about the role and training of the physician's assistant.

In summary, I believe the data in this study support the use of physicians' assistants but suggest that patients feel that their role should be better defined to patients, that they should be closely supervised by physicians, and that their role should be largely limited to routine functions. This does not in any way suggest that physicians' assistants do not deliver high quality medical care. Certainly more data on the role of physicians' assistants in health care are needed and would be welcome.

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Extended Tip Spatula for Cervical Cytology

To the Editor:

I was interested in the article "The Extended Tip Spatula for Cervical Cytology," by V.F. Colon and L.E. Linz *(J Fam Pract 13:37, 1981)*. It is of interest that the literature concerning the use of cotton tipped applicator swabs for the recovery of endocervical specimens for cytologic examination has been well covered, and it is the recommendation of many cytopathologists that this represents a suboptimal method. It is hoped that the introduction of the extended tip spatula will obviate continued discourse concerning the cotton tipped applicators. Dr. Rubio from the Karolinska in Stockholm has commented on this issue most recently in *The Lancet*.

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Reference

1. Rubio CA: "False-negative smears" in gynaecological cytology. Lancet i:979, 1979