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.

Reliability of Computerized Morbidity Data

To the Editor:

The article on reliability of computerized morbidity data (Fortinsky RH, Gutman JD: *A two-phase study of computerized data. J Fam Pract 13:229, 1981)* addresses an area of great importance to the discipline of family medicine, especially with the increase in the use of data systems to capture encounter and morbidity data. I believe that it is important to point out several features not explicitly highlighted in the article. The authors compared two methods of coding diagnoses: (1) the physicians coded their own diagnoses in the first period, and (2) a precoded encounter form was introduced in the second study period. It is important to point out that this study does not look at using front office coder(s) (billing clerk) to do the coding, as is the case in most practices. Moreover, it would have been helpful to know how many problems were noted per visit in each of the study periods and how many different codes were used, since precoded encounter forms might have the effect of forcing physicians to limit the scope of diagnoses used.

The exclusion of status-post diagnoses removed any statistical significance between the two methods. It might have been more useful to have presented the data from the perspective that there was no significant difference unless status-post diagnoses were included.

I would like to point out that there is a published conversion code from ICHPPC-1 to ICHPPC-2.[1]

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Reference

1. Becker LA, Boyle RM, Froom J, et al: A conversion code from ICHPPC-1 to ICHPPC-2. J Fam Pract 12:707, 1981

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

The comments of Dr. Schneeweiss are appreciated. This response will hopefully serve to clarify the conduct and context of our study.

First, although the precoded encounter form was introduced as a medium for data collection in the second study period, the family practice residents remained responsible for recording all health problems on the form. The form did not simply replace physician effort but helped to alleviate the inconvenience of referring to the code book for every health problem. The code book still must be referred to when coding problems not on the encounter form. Therefore, the overall methods of coding diagnoses in each study period are not so different as Dr. Schneeweiss implies.

Second, we did not discuss the use of billing clerks as coders because billing is not currently a function of the Family Care Center data system. We did, however,

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note that additional errors are introduced at the phase of data entry in our setting. It is apparent that reliability is inversely related to the number of personnel included in the process of capturing morbidity data.

Third, it was not possible for us to calculate comparable problems per visit figures because, due to programming limitations, visit based information was not available for the first study period. We were, in fact, more interested in patient based and health problem based reliability because these units of analysis form the basis of much family practice research. We are currently reviewing data to determine whether those health problems on our encounter form now represent a larger proportion of all recorded problems than they did before the introduction of the form.

Finally, Dr. Schneeweiss' comment about status-post conditions is well taken. I would like to know the extent to which other settings attempt to collect such conditions in computerized data systems. While their clinical importance is obvious, it does not seem that their inclusion in computerized systems is common. I hope that researchers in family medicine continue to share such experiences, and I thank Dr. Schneeweiss for his insightful comments on our article.

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Method to Demonstrate the Sclera in the Newborn

To the Editor:

It is often desirable to examine the sclera of the newborn for inflammation, hemorrhage, icterus, edema, and so on. The examiner, however, finds that the palpebral fissure of such patients is only large enough to show the cornea and none of the sclera is visible. In addition, the usually edematous eyelids are closed tightly when they are touched or when the infant is crying. The following method is suggested.

For good results, one must wait until the infant is not crying. Then, with one hand supporting the neck and occiput firmly, the other hand and the examiner's chest support the bottom half of the infant. It is best to hold the infant over a table. The infant may then open his eyes after a short quiet pause. If not, the infant may be raised up gently to a sitting position. This often causes the eyes to open. With infants of less than four days of age, swelling of the eyelids and crying may make these attempts unsuccessful, and one may then have to hold the eyelids apart with a thumb and index finger, the infant still being held against the chest or lying on a table. The following aid will still be successful.

When the eyes are open, the eyeballs move very little and the corneas will be centered straight ahead almost constantly. If now the infant's head is turned smoothly and quickly to the left, the eyeballs will continue to stare at the same point as before the movement. This causes the sclera to the left of each cornea to occupy about one fourth of the palpebral space, where it can be seen. Similarly, turning the head to the right causes the sclera to the right of each cornea to be visible in the palpebral fissure. Thus, all of the temporal and nasal portions of the sclera of each eye can be seen.

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