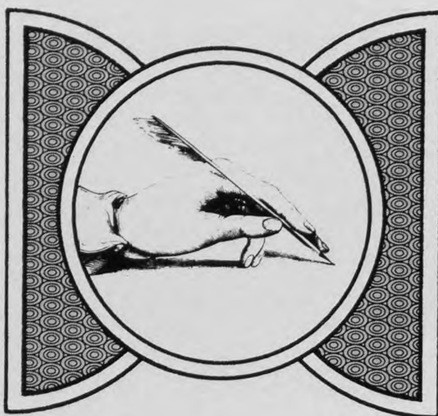
Letters to the Editor



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.

Continuity of Care for Families

To the Editor:

The work of Chatterton, Clapp, and Gehlbach *(Patterns of health care utilization in an academic family practice. J Fam Pract 14: 893, 1982)* sounds a theme heard frequently among family practice educators: there appears to be discordance between patient behavior and family medicine values. A survey conducted by these authors showed that their patients received health care from a variety of providers; in only a minority of cases do all members of a family receive care exclusively from their family medicine center.

It is important to view these and similar findings in context and not be discouraged by them. Chatterton et al correctly caution against extrapolating conclusions from their university center to other settings. Their call for replication of their study in community practices should be heeded. Model family practice units are essential for the education of residents, but they must not be assumed to be completely representative of community practice.

Even if the same behavioral pattern exists in all family practice settings, it should not be seen as evidence of failure on our part. Fragmented care was viewed as the norm by many physicians and patients during the years before the field of family practice was established. Treatment by "specialists" is highly valued in American society for various reasons. The high geographic mobility of Americans, not excluding those around universities, interferes with continuing physician-patient relationships. There are ethical and pragmatic limits on the extent to which family medicine has been able to promote its value system to the public. For these and other reasons, acceptance of the family medicine value system cannot be expected to occur as rapidly as its proponents might wish. Physicians can only recommend; patients have the right to choose whether or not they will comply.

Chatterton et al cite with apparent concern the report of Hyatt[1] that only 62 percent of family physicians in his sample "believe a family physician should take care of all members of a family." One's reaction to this depends on how the question was interpreted by respondents: Were they talking about an ideal, or were they considering what is practical in view of the realities described in the previous paragraph?

The name "family practice" was chosen in the 1960s as the least unsatisfactory of various alternatives. Typical functions as described in the Willard Report[2] include "first medical contact for patients . . . key to referral process . . . integrator . . . insures continuity and comprehensiveness. . . ." Family issues constitute a significant part of the specialty, but not its entirety. Family physicians will stand or fall, not on treating whole families, but rather on fulfilling patient expectations in primary health care. The ideal of family-centered care is worth pursuing, but family physicians should be neither surprised nor discouraged if it remains elusive.

Robert D. Gillette, MD
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References

1. Hyatt JD: Perceptions of the family physician by patients and family physicians. J Fam Pract 10:295, 1980
2. Willard WR (chairman): Meeting the Challenge of Family Practice. Report of the Ad Hoc Committee on Education for Family Practice. Chicago, American Medical Association, 1966

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

What sets family physicians apart from other specialists is, as Dr. Gillette indicates, their willingness and ability to provide or otherwise arrange for the provision of primary, comprehensive, and continuous care to all comers. The absence of barriers to care based on age, sex, or presenting problem makes it possible for an individual physician to care for all members of a given family. This is, however, a secondary, and, in my view, a limited phenomenon.

While some patients may not use family physicians as family physicians might like or expect them to, the fact remains that they do use

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them. I do not think that the future of family medicine is dependent on its success in enrolling families. As Dr. Gillette notes, the future instead hinges on the ability to fulfill patient expectations in primary health care. That a large percentage of patients who identify family physicians as their usual source of care frequently prefer to employ other primary health care providers suggests that family physicians could be doing a better job in this area.

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Diagnosis of Depression

To the Editor:

The recent paper comparing three self-reporting questionnaires for measuring depression in a family practice setting *(Berndt SM, Berndt DJ, Byars WD: A multi-institutional study of depression in family practice. J Fam Pract 16:83, 1983)* pointed out the limitations of these instruments. As the authors mentioned, the questionnaires are designed to provide a measure of the severity of depression, not a diagnosis of depression. The diagnosis must follow from a careful history and physical examination. However, I have been impressed with another application of these depression scales. They can be very useful tools to enhance the patient's acceptance of a diagnosis of depression. A patient will usually accept a high score on a depression scale as "proof" of the diagnosis just as he will accept a report of a low hematocrit as proof of anemia.

Combining the depression scale score with a discussion of the biochemical basis of depression (which seems to help relieve the patient of the "guilt" often associated with the diagnosis) has led to improved patient compliance and better outcomes in my practice. I recommend this use of the depression scales to other practicing family physicians.

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Appropriate Antibiotic Prescribing

To the Editor:

The article by J. Daniel Robinson et al, "Antibiotic Prescribing in a Family Medicine Residency Program" *(J Fam Pract 15:111, 1982)*, is an important and much needed effort in comparing what physicians actually do with what their training has taught them to do. It suffers, however, from two serious flaws: the first is the reliance on a subjective definition of "appropriate," and the second is the absence of a definition even of the subjective use of the term.

Without a definition of the term *appropriate,* the report cannot be translated in practical terms to any of its readers' practices. The objectification of this term is important because every decision to prescribe is a combination of both objective and subjective factors. It ought to be possible to rigorously describe the objective criteria employed, and this will facilitate both further refinement of these objective criteria and critical attention to the importance of the much less easily defined subjective factors.

In addition, the presence of objective criteria for diagnosis does not always specify a treatment. For example, the appropriate treatment of conjunctivitis is most often mere

reassurance; when the use of an antibiotic is appropriate is unclear, even if there is a positive culture for a pathogen, such as staphylococcus.[1]

With the objective criteria set aside, it is possible to focus on the subjective criteria, which include such factors as the intensity of the patient's desire to receive a medication, the presence of insurance coverage, the patient's willingness to withhold treatment pending a culture report, the degree to which the physician feels certain that a specifically treatable diagnosis exists, the availability of the patient for follow-up, the cost for follow-up, and the cost of the initial visit.

As a first consideration I think it is naive to suppose that the physician does not respond, often in some reasonably compromising way, to the patient's pressuring for a medication. I believe that to some extent this is a legitimate consideration—the patient could always have received no treatment by staying home. My own policy, if I am being hard pressed, is to make my convictions absolutely clear to the patient when I do not believe that an antibiotic will do any good. If the patient is still persistent, and if I believe that the risks of a short course of "inappropriate" antibiotics are not substantial, I will comply. What is important is that this kind of bargaining be included in our analysis of what makes a prescription appropriate.

Second, there are cost and feasibility issues. I do office urine and throat cultures routinely; I rarely send cultures out for identification and sensitivity, and only in the presence of severe infection or documented failure of an antibiotic appropriate for the "probable" organism. The results of identification and sensitivity are not available for at least three days and it is a real consideration that the patient has usually lost interest in the report by that time and resents paying the substantial charge. In the absence of a culture and sensitivity, it is impossible to know whether the treatment was scientifically "appropriate."

Finally, physician bias in the face of uncertainty should be considered. How many physicians feel comfortable using an antibiotic for severe exudative pharyngitis, even when the culture is negative for streptococcus? How many institute treatment for streptococcal pharyngitis or urinary tract infection before even an office culture is done? How many physicians treat conjunctivitis or bronchitis with an antibiotic without doing a culture and in spite of the probabilities of a viral pathogen? I suppose that many treat when there is legitimate doubt and the patient desires to be treated.

This second set of questions about the subjective processes when physicians prescribe is important and almost entirely ignored in the literature. They can only get the attention they deserve when they are clearly separated from the objective criteria that are also employed. Thus physicians need both to specify more clearly objective criteria and to abandon the myth that prescribing is, or ought to be, done solely on the basis of objective criteria. Let us open the doors to new research in this area. Robinson's report is a good start; I hope others will embark upon the necessary refinements.

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Winters, California

Reference

1. Gigliotti F: Etiology of acute conjunctivitis in children. J Pediatr 98:531, 1981

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