*In the long, hard fight against obesity*

FASTIN® (IV)

*(phentermine HCl)*
*30 mg capsules*

*Can help.*

**Brief Summary**
Indicated only for use as a short-term adjunct in the management of exogenous obesity.

**INDICATION:** FASTIN is indicated in the management of exogenous obesity as a short-term (a few weeks) adjunct in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class (see ACTIONS) should be measured against possible risk factors inherent in their use such as those described below.
**CONTRAINDICATIONS:** Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma.
Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).
**WARNINGS:** Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should not be exceeded in an attempt to increase the effect: rather, the drug should be discontinued.
FASTIN may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle: the patient should therefore be cautioned accordingly.
**DRUG DEPENDENCE:** FASTIN is related chemically and pharmacologically to the amphetamines. Amphetamines and related stimulant drugs have been extensively abused, and the possibility of abuse of FASTIN should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with intense psychological dependence and severe social dysfunction. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression: changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia.
**Usage in Pregnancy:** Safe use in pregnancy has not been established. Use of FASTIN by women who are or who may become pregnant, and those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and infant.
**Usage in Children:** FASTIN is not recommended for use in children under 12 years of age.
**Usage with Alcohol:** Concomitant use of alcohol with FASTIN may result in an adverse drug interaction.
**PRECAUTIONS:** Caution is to be exercised in prescribing FASTIN for patients with even mild hypertension.
Insulin requirements in diabetes mellitus may be altered in association with the use of FASTIN and the concomitant dietary regimen.
FASTIN may decrease the hypotensive effect of guanethidine.
The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.
**ADVERSE REACTIONS: Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure.
**Central Nervous System:** Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache: rarely psychotic episodes at recommended doses.
**Gastrointestinal:** Dryness of the mouth, unpleasant taste, diarrhea, constipation, other gastrointestinal disturbances.
**Allergic:** Urticaria.
**Endocrine:** Impotence, changes in libido.
**DOSAGE AND ADMINISTRATION: Exogenous Obesity:** One capsule at approximately 2 hours after breakfast for appetite control. Late evening medication should be avoided because of the possibility of resulting insomnia.
Administration of one capsule (30 mg) daily has been found to be adequate in depression of the appetite for twelve to fourteen hours.
FASTIN is not recommended for use in children under 12 years of age.
**OVERDOSAGE:** Manifestations of acute overdosage with phentermine include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension, and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management of acute phentermine intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard. Acidification of the urine increases phentermine excretion. Intravenous phentolamine (REGITINE) has been suggested for possible acute, severe hypertension, if this complicates phentermine overdosage.
**CAUTION:** Federal law prohibits dispensing without prescription.
**HOW SUPPLIED:** Blue and clear capsules with blue and white beads containing 30 mg phentermine hydrochloride (equivalent to 24 mg phentermine).
NDC 0029-2205-30 .......... bottles of 100
NDC 0029-2205-39 .......... bottles of 450
NDC 0029-2205-31 .......... pack of 30

Beecham
laboratories
Bristol, Tennessee 37620

# 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.*

## REMUNERATION OF FAMILY PHYSICIANS

To the Editor:

I read Brody's article, "The Better Half of the Resource-Based Relative Value Scale" (*J Fam Pract 1990; 30: 190–192*), and I applaud Dr Brody for the position he is taking regarding the RBRVS legislation. We must take courageous positions in dealing with the rising cost of medical care and in determining how we as a discipline can do our part to make health care more accessible in a high-quality, cost-effective manner. For the hours invested in practice, our incomes are reasonable. There are many family physicians, however, who barely reach the income of a well-paid school teacher. When one adds to this the hours worked, one makes a strong argument that many family physicians, especially those in rural settings, are not well remunerated.

*Nikitas J. Zervanos, MD*
*Director, Family and Community Medicine*
*Lancaster General Hospital*
*Lancaster, Pennsylvania*

To the Editor:

Dr Brody's recent article[1] offers a scholarly review and a creative response to an important and complex issue. However, we must object to his suggestion of suspending or forgoing the battle to raise the relative income of the time-intensive services of primary care physicians or mental health care providers.

Primary care clinicians, especially family physicians, as well as most mental health care providers, including psychiatrists, psychologists, and family therapists, are struggling to meet rising overhead costs, to stabilize their own take-home salaries, and to attract and support new partners (who enter practice with increasing education debts to repay).[2] Over the last several years, the increase in income of procedure-oriented subspecialists has been dramatic relative to the increase in income of primary care physicians and professionals offering mental health care services. Primary care physicians and mental health care providers must be able to recover their costs for spending time with patients and realize an increase in net income or we will simply learn to live without these professionals.

Accepting Dr Brody's suggestion to avoid the realities of economic conflict (which may see a reduction in the reimbursement for procedural activities to accommodate an increase in time-intensive services) allows those of us already in the system to remain comfortable at the expense of future clinicians and patients. Dr Brody's proposal simply ignores the necessity of the approaching confrontation, which is essential to realign the medical system and reach an effective solution. We cannot be timid or indirect in this struggle with our colleagues. We need subspecialists as well as primary care physicians and mental health professionals. However, we must be able to honestly state, "I respect you very much. But, I propose that you are paid too much and I am paid too little. Let's talk about it." To do less is to deny the fundamental importance of this issue, which may destroy a potentially rational medical care delivery system by slow attrition of providers giving primary and cognitive care.

There is no painless way to reorient the medical system. As an economically driven system, it will respond somewhat predictably to economic incentives. Changing these

incentives will cause conflict among friends. Dr Brody has made many contributions to family medicine and to all of medicine. Out of respect for him, we disagree openly rather than behind the curtain of the geographic distance between us. Similarly, we can disagree with our subspecialty friends and learn from the interchange.

*Macaran A. Baird, MD*
*William D. Grant, EdD*
*Department of Family Medicine*
*State University of New York*
*Health Science Center,*
*Syracuse, New York*

#### References

1. Brody H: The better half of the resource-based relative value scale. *J Fam Pract* 1990; 30:190–192
2. Wilke RJ, Cotter S: Young physicians and changes in medical practice characteristics between 1975 and 1987. Inquiry 1989; 26: 84–89

## SAMPLING METHODS IN FATIGUE STUDY

To the Editor:

I applaud Drs Kirk et al[1] for conceiving, implementing, and reporting on a cooperative research effort that took place in the offices of multiple primary care providers. I believe that this investigation illustrates the wave of the future in primary care research and that others would do well to emulate their approach. I also wish to congratulate them on their lucid discussion of dropout bias. From a purely statistical viewpoint this bias can represent a hindrance to interpretation of results. From a primary care viewpoint, however, the finding that so many patients dropped out of the study (46% were eventually lost) in itself allowed investigation of demographic differences between patients who maintained continuity of care and those who did not.

I would like to discuss two other closely related sources of bias that were present in this study but not discussed in the published report: sampling bias and selection bias. According to the authors, approximately one half of the fatigue cohort was recruited from among a sample of 1227 patients who represented a series of 20 consecutive adult patients presenting to each cooperating practice during the course of another study. Presumably, therefore, one half the cohort was identified during a brief "slice of time." It is unclear to me whether this sampling method biased the results in any way. If, however, the chief complaint of fatigue was increasing (or decreasing) rapidly over time, or was related to seasonality in some way, the results might have been different had the sample been obtained more uniformly over an extended period.

The second bias not addressed in the article was selection bias (on the part of the participating physicians). Patient selection criteria were clearly explained, and each of the participating practices was said to have contributed about six patients to the study. Although I may be mistaken, I assume that this number of patients represented only a small fraction of those eligible to be included. If my assumption is correct (if not all eligible patients were included), there is the possibility for significant selection bias. For example, were patients with a particular type of fatigue (physical or psychological) more or less likely to be offered participation, or more or less likely to accept participation if it was offered? This type of selection bias can be controlled at least partially if all eligible study subjects are *systematically* identified and offered participation and if all refusals are documented. From a reading of the article, I was unable to determine whether this had been done. From personal experience I have found it very difficult to obtain systematic sampling and selection of study subjects in a cooperative, multisite study involving busy office practitioners.[2] My hat is off to the authors of this study, therefore, if they were able to perform systematic selection.

My purpose in writing is not to criticize the methods of a study, which I consider to be a prototype of things to come. Rather, I wish to point out a methodologic problem of fundamental importance to the future of cooperative primary care research. It takes extra time and effort to obtain systematic samples from busy practices. My personal opinion is that the only way to obtain this support from busy physicians is to point out the shortcomings of studies that are based on what epidemiologists call a "grab sample" rather than on a systematic sample of patients who may more closely represent the true universe of patients seen in our offices.

*David L. Hahn, MD*
*Wisconsin Research Network*
*Steering Committee*
*Arcand Park Clinic*
*Madison, Wisconsin*

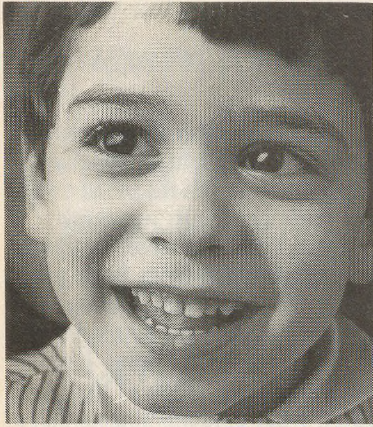
#### References

1. Kirk J, Douglass R, Nelson E, et al: Chief complaint of fatigue: A prospective study. J Fam Pract 1990; 30:33–41
2. Hahn DL: Logistical issues of an office-based cooperative research project: TWAR. Presented at the Third Annual Wisconsin Research Network (WReN) Conference, November 1989, Wausau, Wisconsin

*The preceding letter was referred to Dr Kirk, who responds as follows:*

Dr Hahn appropriately asks how representative our fatigue cohort is of the universe of patients reporting fatigue to their physicians. I can try to address both the sampling and selection bias issues together.

The 154 patients in the sample were collected over a 6-week period. As described in our Methods section, about one half of these patients were identified during a data-collection period in which 20 consecutive adult patients in each of our 28 practices were being entered for a separate study requiring completion of a questionnaire on functional health status. This means that about one out of every 10 to 12 patients in that consecutive series of patients was identified by the physician as having fatigue as the chief reason for the visit. I suspect that our physicians captured close to 100% of the chief-complaint-fatigue




# THE FIRST PART OF THE BODY THAT MUSCULAR DYSTROPHY AFFECTS.

It's hard to smile when you lose the ability to walk. To play. To draw pictures. To climb a tree.

But that's what happens when a child has muscular dystrophy.

"Muscular dystrophy" is the name for a group of diseases that weaken and destroy the muscles. The disorders are progressive, so things get worse over time. The muscle loss can't be stopped. And it can't be reversed.

The Muscular Dystrophy Association is striving to cure muscular dystrophy. And on Christmas Eve of 1987, MDA researchers announced a landmark advance: discovery of the cause of the most terrible form of muscular dystrophy, *Duchenne*.

Now a giant step toward curing these dread diseases has been taken. And MDA researchers are forging ahead, racing to save the children stricken today.

MDA receives no government grants or fees for services — its work is funded entirely by private donations. You can help MDA fight muscular dystrophy and dozens of other muscle diseases by sending a tax-deductible contribution today.

Don't wait until a child's smile reminds you of all the children who have *stopped* smiling. Please send your donation today.

MDA®

Muscular Dystrophy Association
Jerry Lewis, National Chairman



patients in that sample because of the special attention to data collected during this sampling time. I doubt that they "overidentified" fatigue patients, because our inclusion criteria were fairly objective.

I am concerned, however, that we may have underreported fatigue in the weeks ahead, at least in some of the practices. Most of the practices finished the rest of the cohort identification in the next 2 to 3 weeks.

To prevent oversampling, the experience of a few practices, we stopped at a maximum of six patients from each practice. Some of the practices took up to 6 weeks to identify their six patients. We presume the incidence of fatigue remained constant during the 6 weeks, yet the rate of identification of cases varied during the study. We trust the later entries were similar to the earlier entries, that missed cases were related to "random" office variables such as scheduling and time pressures, but it is possible they represented more seriously fatigued cases that stood out from the others during the later, less intense data-collection period. We do not have the means at this time to correlate data of entry with other parameters in the study.

We thank Dr Hahn for the pertinent and valuable observations, and we appreciate his words of encouragement.

*Jack Kirk, MD*
*Dartmouth COOP Project*
*Hanover, New Hampshire*

## FAMILY PRACTICE AS A SPECIALTY

To the Editor:

As a faculty member with special interest in predoctoral family medicine education, I follow closely the literature on specialty selection. I read with great interest "Who Goes Into Family Medicine?" by Agnes G. Rezler and Summers G. Kalishman in the December issue of the Journal (*J Fam Pract 1989; 29:652–656*). Unfortunately, this article contains such a blatant error that I feel compelled to write in protest.

Rezler and Kalishman repeatedly refer to students switching from family practice *to a specialty*. In their second study, they divided practicing physicians into two categories: family medicine or specialist. I am simply appalled to see this language in *The Journal of Family Practice*.

Family practice is one of the 23 recognized medical specialties in the United States; it was established as such over 20 years ago. Many of us in the field fight daily battles to be recognized as specialists, equal in status to our colleagues who have chosen more limited areas of expertise. Perhaps the authors of this article, as nonphysicians, were unaware of these facts. The failure of the Journal staff to correct these errors, however, is unforgivable.

Rezler and Kalishman may be correct in their assertion that medical schools should adjust their selection criteria in favor of students more likely to become family physicians, but our retention of these students is unlikely to improve unless family practice is viewed as a viable medical specialty with reasonable status in the medical community. Progress is being made in that direction. I am afraid, however, that if our own literature supports the opposing viewpoint, we may be destined to fail.

*Victoria S. Kaprielian, MD*
*Division of Community Medicine*
*Duke University Medical Center*
*Durham, North Carolina*