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. All letters that reference a recently published Journal article are sent to the original authors for their reply. If no reply is published, the authors have not responded by date of publication. Send letters to Paul M. Fischer, Editor, The Journal of Family Practice, 519 Pleasant Home Rd, Suite A-3, Augusta, GA 30907-3500, or Fax (706) 855-1107.

HEALTH CARE REFORM

To the Editor:

In their article about primary care physicians' views on health care reform (*Millard PS, Konrad TR, Goldstein A, Stein J. Primary care physicians' views on access and health care reform: the situation in North Carolina. J Fam Pract 1993; 37:439–44*), Dr Millard and colleagues documented that there was no consensus among primary care physicians about which plan is preferred, given a choice between a fee-for-service plan, a single payer plan, and a managed competition plan.

Family physicians and general practitioners preferred the current system to a managed competition plan or single payer plan. Almost one third of the physicians indicated they did not have enough information to make an informed choice. The article was written prior to publication of the President's proposal, which is being called "managed cooperation" in an attempt to explain that it is an attempt to combine managed competition and strong government regulation.

In late October, I conducted a random survey of one out of five Oklahoma family physicians. Over 56% indicated they did not feel that they had enough information to have an opinion about President Clinton's plan. Of those who did feel they had adequate information, opponents to the plan outnumbered proponents by 5 to 1. Over 79% wanted to receive information about alternative plans being considered at a national level. A total of over 92% of family physicians expressed views that were not consistent with the official position of the American Academy of Family Physicians, which has endorsed the President's proposal.

It appears that although the leadership of the American Academy of Family Physicians supports President Clinton's proposal, this opinion is not representative of a majority of family physicians in Oklahoma and North Carolina.

Glenn P. Dewberry, Jr, MD
Oklahoma City, Oklahoma

ALZHEIMER'S ADVANCES

To the Editor:

Since I have just completed 12 years of dealing with my wife's Alzheimer's syndrome, I was impressed by the excellent summary of the entire problem by Dr Roth (*Roth ME. Advances in Alzheimer's disease: a review for the family physician. J Fam Pract 1993; 37:593–607*). The tables were particularly instructive in their usual concise way. The discussion of the complex mechanisms of neurochemistry was well done. The disappointment with the impact of medication I can confirm.

The "neuro-medication" of the Alzheimer's patient to control and minimize the mood changes and their resultant behaviors is an extremely fine art that many family physicians would do well to study diligently. As usual in the elderly, the dosages must start—and often remain—small, and the tailoring of combinations of psychotropic drugs needs much study. I doubt that one can identify a standard combination of medications that one can prescribe over time for these people.

I heartily agree that, as family physicians, we are the most likely to have lifelong records on Alzheimer's patients which may help someone to detect possible correlations with other events in the lives of these patients, such as dyslexia, major psychological traumata, and other medical and nonmedical events.

J. B. Deisher, MD
Redmond, Virginia

PSYCHIATRIC SCREENING

To the Editor:

Regarding Dr Zimmerman's article on the brief psychiatric interview (*Zimmerman M. A five-minute psychiatric screening interview. J Fam Pract 1993; 37: 479–82*), this attempt to compress "an hour-long anamnesis" is admirable, but fails to produce a user-friendly tool for mental health screening in family practice. There are several problems here.

The interview is too broad for the average patient encounter. Questions about social and simple phobias, psychosis, and eating disorders are of limited value. Psychotic disorders are uncommonly encountered. Social and simple phobias are common but do not cause the generalized dysfunction that other anxious states and depression cause. Eating disorders usually come in packages with depression and anxiety, and their presence could be explored if depression or anxiety is found.

The screening questions for depression lack sensitivity. Perhaps 50% of depressed patients suffer from alexithymia, difficulty expressing their emotional state in words. This makes the question "Are you sad?" a poor one for screening. Dysthymic patients, who outnumber patients with "major" depression in our practices, may have been sick so long that asking about loss of interest fails to yield needed information. In dysthymic states, the illness may be "normalized" by patients and family members. Physicians should be asking about sleep abnormalities, fatigue, irritability, and other symptoms of depression. They would also benefit from using associated diagnoses and depression euphemisms as triggers for a more thorough historical investigation. Thus, everyone with headaches, fibromyalgia, chronic fatigue, irritable bowel syndrome, nonulcer dyspepsia, and the like would be properly assessed for depression.

The interview depends too heavily on the DSM III-R (*Diagnostic and Statistical Manual of Mental Disorders*, Third Edition, Revised). Translation of the DSM's seemingly arbitrary symptom delineations into family practice is often cumbersome and confusing. Its failure to recognize that anxiety and depression usually coexist is a good example of this. It also fails to highlight the subsyndromal illness that we see. Our specialty still needs a *clinically relevant* nosology for these disorders.

Family physicians would benefit from a practice-based and researched assessment tool designed to provide a comprehensive database for the physician's encounter with the depressed patient.

J. Sloan Manning, MD
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The preceding letter was referred to Dr Zimmerman, who responds as follows:

Dr Manning raises a number of issues in his letter, and I will comment on them in the order they are presented.

1. The 5-minute screening interview is not an attempt to "compress an hour-long anamnesis." Rather, it is a brief interview that includes questions that, when answered negatively, rule out the disorder, but when answered positively, need to be followed up with more detailed questioning.

2. I agree that psychotic disorders are relatively rare in family practice, and perhaps they should not be inquired about. In the Epidemiologic Catchment Area study, the 1-month point prevalence for schizophrenia was 0.7%.[1] However, drug abuse/dependence was less than two times as frequent (1.3%), and panic disorder was less frequent than schizophrenia (0.5%). I do not know how prevalent a disorder should be before routine inquiry should be made.

3. In contrast to Dr Manning's suggestion, the research on social phobia demonstrates that there is significant psychosocial morbidity associated with this disorder.[2]

4. There is a large amount of literature on the relation between eating disorders and depression, which indicates that there are high levels of comorbidity between the two disorders.[3,4] As many as 50% of eating disorder patients do not have a concomitant depression, however, and it would be inappropriate to assess eating disorders only when a mood disturbance is present.

5. I am unaware of any research demonstrating marked symptom differences ric patients. In fact, most studies have reported great similarities in presentation.[5] Moreover, the screening question I suggested was not "Are you sad?" but rather, "How would you describe your mood? Have you been feeling sad, blue, down, or depressed?" "Have you lost interest in, or do you get less pleasure from the things you used to enjoy?"

6. Once again, turning to the scientific literature, major depression is more common than dysthymia disorder.[6,7]

7. The issue of mixed anxiety-depression and "subsyndromal" forms of illness have received increased attention during the past several years, and these categories will be included in the new edition of DSM-IV (*Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition).

8. Finally, Dr Manning inquires about a researched assessment tool to aid clinicians in their evaluation of depressed patients. There are many self-administered questionnaires that validly and reliably quantify the symptoms of depression. Several years ago, I developed one such instrument, the Inventory to Diagnose Depression,[8] and recent studies have demonstrated its utility in assessing depression in medical patients.[9,10] I caution Dr Manning, though, in focusing on depression to the exclusion of other forms of pathology. Our research suggests that psychiatric screening in medical patients has been too narrowly focused on depression, and the clinical practice guidelines for depression in primary care recently published by the Agency for Health Care Policy and Research[11] emphasize the importance of detecting and considering psychiatric comorbidity when evaluating medical patients for depression.

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CD-ROM

To the Editor:

I appreciate *The Journal*'s coverage of computers and their hardware and software. Medicine *can* come into the 21st century with all this newfangled stuff.

Mark Ebell's article on CD-ROM in the November issue (*Ebell MH. CD-ROM: a primer for physicians. J Fam Pract 1993; 37:483–7*) was very instructive about the general concept and about IBM clones. Unfortunately for me, I have a Macintosh, and there was no mention of hardware or software available for "ol' Mac." Perhaps a future article could cover that side of things. I suspect that there are more than a few of us Mac users out there.

J. B. Deisher, MD
Redmond, Washington

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

I apologize for the PC bias in my article on CD-ROM drives. It reflects my lack of knowledge of the Macintosh platform more than any inherent bias against it! Fortunately, most of the material discussed in the article also applies to the Macintosh. For example, the ISO 9660 standard, which determines how information is encoded on the disk, is used by both IBM-compatible and Macintosh platforms. However, because of software incompatibilities, it is not possible for a Macintosh to use CD-ROM disks written for the PC, and vice versa.

The hardware specifications recommended in the article apply to both platforms. Users should look for a double-speed or faster drive (300 K/sec or

greater transfer rate) with an access time less than 300 milliseconds, and Multisession Photo CD capability. Good drives are made for the Macintosh by a variety of manufacturers in both internal and external configurations. The drives are a little more expensive for the Macintosh, perhaps $50 to $100 more on average.

A wide variety of medical, educational, and entertainment software is available for both the Macintosh and PC. Many of the titles mentioned in the article are available for the Macintosh, including the *Scientific American Medicine* (Scientific American Medicine, New York, NY), *Family Doctor* (Creative Multimedia Corporation, Portland, Ore), *STAT!-Ref* (Continuing Medical Education Associates, San Diego, Calif), the *Mayo Clinic Family Health Book* (Sony Electronic Publishing, Los Angeles, Calif), and a number of journal compilations.

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