# LETTERS TO THE EDITOR

## HCFA'S NEW CODING GUIDELINES

To the Editor:

When our article,[1] which appeared in the July issue of the *Journal*, was originally written, the Health Care Financing Administration (HCFA) was planning to enforce its new coding guidelines. The HCFA has since postponed implementing its reviews of evaluation and management coding by physicians. It is still important, however, for physicians to learn Current Procedural Terminology coding, since it is likely that the HCFA will announce new coding guidelines and implement penalties for failure to follow them.

*Jason Chao, MD*
*Case Western Reserve University*
*Cleveland, Ohio*

### REFERENCE

1. Chao J, Gillanders WG, Flocke SA, Goodwin MA, Kikano GE, Stange KC. Billing for physician services: a comparison of actual billing with CPT codes assigned by direct observation. J Fam Pract 1998; 47:28-32.

## ETHNICITY AND RATES OF OVERWEIGHT

To the Editor:

The article by Noel et al[1] in the *Journal* demonstrates that the proportion of primary care patients in Michigan who are overweight is higher than predicted by other surveys. In June 1997, the body mass index (BMI) of 369 consecutive patients aged 18 to 65 was measured using similar measures at two large primary care group practices at the University of California, San Francisco. The prevalence of overweight in this group (defined as BMI >27.3 for men and BMI >27.8 for women) was 41.0%. The rates of overweight among men and women were similar (42.1% vs 40.7%). Our patient population is racially diverse, however, and in contrast to the findings from Michigan, the rates of overweight in our practices varied dramatically according to racial group. In our clinics, 19% of Asians, 36% of non-Hispanic whites, 66% of Hispanics, and 69% of African Americans were overweight. While a national program such as Walk America, as suggested by the authors, would be a step in the right direction for many patients who need to lose weight, programs should also be developed that are adaptable and sensitive to the specific needs of racial, ethnic, or other identified groups that may suffer disproportionately from obesity.

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### REFERENCE

1. Noel M, Hickner J, Ettenhofer T, Gauthier B. The high prevalence of obesity in Michigan primary care practices: an UPRNet Study. J Fam Pract 1998; 7:39-43.

## DOMESTIC VIOLENCE RESEARCH

To the Editor:

Doctors Oriel and Fleming, in their article "Screening Men for Partner Violence in a Primary Care Setting: A New Strategy for Detecting Domestic Violence,"[1] address the fact that a patient's disclosure of such illegal and harmful behavior in an anonymous fashion would "not allow intervention." This should be the concern of anyone who researches behaviors that might be injurious to others.

The authors, however, do not address what might occur after a person is asked about his violent behavior and then returns home to the person most often victimized. The men in this study were given resource information on domestic violence, yet their partners may have been placed at great peril. Were the study subjects at the physician's office accompanied by their victim? Are the victims also patients in this clinical practice? Is there any way we can follow up to determine whether this study placed victims at greater harm? Can we be certain that imbedding the questions in a larger study sufficiently masked the study's true emphasis? How was the study explained to the subjects? Did the subjects know that they would be asked questions about violent or aggressive behavior toward others? How did the risk for injury to the victim increase, if at all, by mailing an unsolicited questionnaire to the men missed in the clinical setting? Does using two distinct methodologies alter the reliability of the results?

In the discussion section, the authors report that "men in a primary care setting willingly answered questions about violent behavior toward their spouses." Earlier in the paper, however, the authors reported that only 64% of the subjects were married. One must take care to define domestic violence to include relationships outside of marriage (eg, a significant other whether she lives or does not live in the same residence, the girlfriend of a married man, and so forth). I would also

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challenge whether subjects willingly gave these answers or were duped into providing this information by a more global explanation of the purpose of the study.

I ask these questions so researchers in violent behavior can make certain their study meets not only the letter but the spirit of ethical and safe research. We need to know this kind of information so that we can provide appropriate interventions for both the victim and the perpetrator, but most of all, we must do no harm.

*Mary K. Lawler, PhD, RN*
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**REFERENCE**

1. Oriel KA, Fleming MF. Screening men for partner violence in a primary care setting: a new strategy for detecting domestic violence. J Fam Pract 1998; 46: 493-8.

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

Dr Lawler raises several ethical questions specifically regarding our study that pertain to interpersonal violence research in general. She proposes that by asking men to complete the Conflict Tactics (CT) scales,[1] the most widely used instrument to measure interpersonal violence, we may have caused them to inflict greater harm on their partners. There is no evidence to suggest that questions about interpersonal violence escalate violent behavior, nor is there literature that assures us that those questions carry no risk. We believe, however, that violence due to the study questions is highly unlikely for several reasons. The CT scales focus on specific behaviors, so perpetrators do not need to recognize these behaviors as abusive to respond positively. The CT scales have been used in three nationally representative samples of US couples, and in more than 200 other studies using a variety of methodologies.[2,3] If answering questions regarding specific behaviors caused an escalation in violence, this trend would surely have been noticed. The CT scales are also used in the treatment of partner-assaultive men. Programs have both the abuser and the victim complete the CT scales to follow progress. Mental health professionals working with these couples have not reported an increase in violence following the administration of the survey.

Participants in our study were told that it was about "health and relationship" issues; most persons probably did realize that we were interested in specific ways of dealing with relationship conflict, including violence. Potential subjects were informed that all men were approached for participation, so no one would feel singled out. Partners of subjects may have accompanied them to appointments, but the men participated privately and filled out the survey alone.

Dr Lawler properly chastises us for our use of the word "spouses" on page 496. In that sentence, we meant partners, whether married or not, and should not have used a term that connotes married partners.

In the past, health care professionals worried that if they asked about suicidal ideation or teenage sexual activity, it might cause more of that behavior. We have learned that this is not so. It is possible that by asking about violence, men may recognize their own behaviors as problematic. The next step in this research is to design an intervention. By following both the perpetrator and his partner, we can then determine whether we can reverse this tragic and deadly reality. As researchers, we must never harm a few in the name of a greater good. We must also not allow the mere possibility of violence, however remote, to paralyze us in our search for meaningful information regarding this complex issue. If we do, we allow the abusers to gain power over all of us through their tyranny of violence.

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**REFERENCES**

1. Straus MA. Measuring intrafamily conflict and violence: The Conflict Tactics (CT) scales. J Marriage Fam 1979; 41:75-8.
2. Aldorondo E, Sraus MA. Screening for physical violence in couple therapy: methodological, practical, and ethical considerations. Fam Process 1994; 33:425-39.
3. Fleming MF, Barry KL, Manwell LB, Johnson K, London R. Brief physician advice for problem alcohol drinkers. A randomized controlled trial in community-based primary care practices. JAMA 1997; 277:1039-45.