LETTERS TO THE EDITOR

Inaccurate Web Site Review

To the Editor:

DynaMed is an Internet-based point-of-care reference covering more than 2000 diseases. DynaMed is free, has an evidence-based focus, and is updated daily based upon current reviews of the literature.

Unfortunately, the recent software review in the *Journal* (1998; 47:388-9) that purported to be of DynaMed was mostly about a different site. The reviewer apparently looked at both DynaMed (http://www.DynamicMedical.com) and the Doctor's Guide to the Internet (http://www.docguide.com); the vast majority of the review applies to the Doctor's Guide, prepared by P/S/L Consulting Group, Inc, which is not associated with DynaMed.

The mission statement quoted in the review relates to the Doctor's Guide. DynaMed is intended for health care professionals as a quick reference guide for clinically relevant information, with the capacity to include and improve with user input. As a continuously updated site, DynaMed will always be a work in progress.

DynaMed does not have any sponsors except for a nonfinancial endorsement from the Pennsylvania State University/Good Samaritan Hospital Family and Community Medicine Residency Program. It most assuredly does not have a list of 43 drug company sponsors. We do anticipate searching for advertisers for financial survival, but this has not happened as of December 15, 1998.

DynaMed does not interface with 4 search engines or with the Doctor's Guide and would not lead to the search described in the review. Searching for "smoking cessation" in DynaMed would lead to 17 documents, the first of which would provide summaries of many "clearly important articles" with sources such as the Cochrane Library and POEMs, as well as links to patient information handouts. DynaMed also has nothing to do with continuing medical education (CME) conferences, and the described search must have been on the P/S/L site.

The published review is not an accurate assessment of DynaMed. Obviously, something went wrong with the reviewer's methodology to lead to a review focused on the wrong site.

DynaMed is one of the few medical sites to receive the highest (5-star) rating from Medical Matrix. Check it out for yourself at http://www.DynamicMedical.com to see its clinical utility.

Brian S. Alper, MD
DynaMed

The preceding letter was referred to the reviewer, Dr Bryan Goddard, who responds as follows:

On receiving Dr Alper's letter regarding my review, I rechecked the site. Since the time that I did the review, my hospital has changed its browser, so I had to re-enter the URL. I found a very different site from the one I reviewed. I apologize for my error.

Deeply embarrassed, I tried to identify how I could go so wrong. With Dr Alper's input, this is what I have learned. The hospital removed all traces of the old browser, so I cannot find the bookmark I used repeatedly. When I did my initial search (for www.dynamed.com), my browser said it couldn't find the site (which is found at www.DynamicMedical.com), so I used my browser's search tool to try to find the site. The browser's search tool brought me to the site I reviewed. Dr Alper was able to identify that site as the Doctor's Guide, which has a link to DynaMed.

An embarrassing lesson from the school of hard knocks: Get the URL exactly right.

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Dr Gary Fox, software review editor, also responds:

After receiving Dr Alper's letter, I visited the referenced sites and believe that the review of DynaMed indeed does not reflect the DynaMed site. The closest analogy I can draw to DynaMed is to *Griffith's 5 Minute Clinical Consult*. The DynaMed site has an alphabetical listing of diseases with hyperlinks and links to other sites and documents, such as for patient education. For the diseases I viewed, the information on DynaMed is more comprehensive than *5 Minute Consult* and more clinically focused than most texts. I looked at several topics on which I felt up to date, such as herpes zoster and giant cell arteritis. The monographs in DynaMed were well done and would have complemented my literature reviews nicely—and would have saved me significant time if I had needed information quickly to make clinical decisions and educate patients.

Especially as long as it remains free, I can easily see using DynaMed to replace or complement my literature reviews for subjects that I need to brush up on. My apologies to the readers, Dr Alper, and Dr Goddard for my insufficient familiarity with these Web sites (prior to Dr Alper's letter) to catch that our review focused on the wrong one.

Gary N. Fox, MD
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The Relevancy of Patient-Based Assessments

To the Editor:

We read with great interest the recent article by Safran and colleagues[1] on primary care performance and outcomes. Although we are glad to see the results pointing to the importance of key dimensions of primary care, we are not as confident in the meaningfulness of the results. For example, comprehensiveness in the lexicon of primary medicine usually denotes physician care of a majority of the patient's health needs, not the patient's assessment of the physician's knowledge of the patient. In the Institute of Medicine's definition, "comprehensiveness" refers to the extent to which the physician cares for "a large majority of a patient's personal health care needs."[2] The measurement of knowledge used by the authors does not seem to reflect this construct. Even if it could be argued that clinical knowledge of the patient is an important component of comprehensiveness, it is questionable whether the author's measure of knowledge reflects this. Patient perceptions of the amount of knowledge the physician has may not accurately reflect the true clinical knowledge the physician has about the patient. This perception may be a reflection of a more general issue of the patient-physician relationship rather than comprehensiveness or other aspects of primary care.

Safran and coworkers appropriately point out the limitations of patient-based assessments of technical aspects of care; however, it seems reasonable that patient-based assessments of the amount of knowledge that their doctor has about them may suffer from some of the same limitations. Other measures have similar limitations in their ability to reflect the components of primary care as outlined by the Institute of Medicine. For example, it is unknown whether patient perceptions can accurately reflect the integration of care.

Consequently, the results should be interpreted in light of some critical issues regarding operational definitions of general constructs.

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REFERENCES

1. Safran DG, Taira DA, Rogers WH, Kosinski M, Ware JE, Tarlov AR. Linking primary care performance to outcomes of care. J Fam Pract 1998; 47:213-20.
2. Institute of Medicine. Primary care: America's health in a new era. Washington, DC: National Academy Press, 1996.

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

Drs Mainous and Gill ask about our decision to classify one of the scales from the Primary Care Assessment Survey (PCAS)—a measure of the primary physician's contextual (whole-person) knowledge of the patient—as an indicator of comprehensiveness. They note that comprehensiveness of care more typically denotes the extent to which a physician "cares for a large majority of a patient's personal health care needs." Indeed, our measure of "contextual knowledge of the patient" does not capture this majority of care concept. It is not intended to. However, neither is the scale intended to measure the physician's clinical knowledge of the patient, as Drs Mainous and Gill suggest, before they go on to express concern about patients' ability to assess that domain. The scale is a measure of the primary physician's knowledge of the patient. This includes, but is not limited to, the physician's knowledge of the patient's medical history. The scale measures the extent to which there is a whole-person orientation to the care that the patient receives from the primary physician. Items from the scale assess such things as the physician's knowledge about the patient's principal health concerns, life circumstances, values, and beliefs. As the Institute of Medicine underscored in its recent definition of primary care, a whole-person orientation is part of what distinguishes primary care from areas of medicine that are disease- or organ-focused.[1] It probably comes as no surprise to most primary care clinicians that this prized feature of primary care—knowing one's patients not just in clinical terms, but as whole human beings—is closely associated with important outcomes, including patients' adherence to their physician's advice.[2] There is another scale from the PCAS that more closely captures the majority of care concept—which Drs Mainous and Gill rightly point to as the traditional view of comprehensiveness in primary care. The visit-based continuity scale from the PCAS assesses how often the primary physician is the person from whom the patient receives his or her medical care. While our data suggest that visit-based continuity is highly valued by both patients and physicians, it was less closely associated with the 3 outcomes of care that we studied than other PCAS scales.[2]

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REFERENCES

1. Institute of Medicine. Primary care: America's health in a new era. Washington, DC: National Academy Press, 1996.
2. Safran DG, Taira DA, Rogers WH, Kosinksi M, Ware JE, Tarlov AR. Linking primary care performance to outcomes of care. J Fam Pract 1998; 47:213-20.