

ARCHIVES

OF

FAMILY MEDICINE

MAY/JUNE 1997



See Special Selection, page 213.

PERIODIC HEALTH EXAMINATIONS
AND DELIVERY OF CANCER
PREVENTION SERVICES

DOCTOR-PATIENT COMMUNICATIONS

MODIFIABLE HIGH-RISK BEHAVIORS
FOR CARDIOVASCULAR DISEASE AMONG
FAMILY PHYSICIANS

THE ELECTRONIC HOUSE CALL

DICLOFENAC IN LATERAL EPICONDYLITIS
OF THE ELBOW ALSO TREATED
WITH IMMOBILIZATION

THE DEPARTMENT WITHOUT WALLS

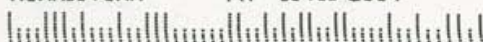
#BXNBBPM***** 5-DIGIT 19401 #
#011455862042#05C 1811 007830
CHARLES KING MERVINE III MD 0614 *
0011
003

American Medical Association

Physicians dedicated to the health of America



1500 SANDY HILL RD
NORRISTOWN PA 19401-2604



The nature of the interventions used by primary care physicians leads to my second observation. The researchers would seem to have been generous in giving "credit" for counseling when as little as 3 minutes of supportive, problem-based counseling was provided. Yet, I am frequently struck by the apparent positive influence such limited counseling can have, at least as attested by the profuse gratitude expressed by many patients. I take this gratitude not to mean that my words have some particular curative power, but rather that the symbolic importance of taking what is actually a notable portion of a short visit to validate the importance of their anxious or depressive symptoms can lead to other curative behaviors, including medication compliance and referral.

The third finding worth noting is that patients who were anxious were more likely to receive treatment when depression was present as well, suggesting again that primary care physicians are responding to the total presentation of distress and dysfunction, regardless of their formal recognition of criterion-based diagnoses. On the other hand, they may also be responding to the severity and nature of symptoms and inappropriately treating distress rather than a treatable disorder. This study finding is the one that generates the most curiosity and seems to beg for further study, perhaps using richer data on fewer patients and physicians so that we might learn why physicians choose certain cues to respond to and how they respond to the cues they choose.

My final reaction concerns the interspecialty differences in treatment. The likely reason that patients who have anxiety disorders superimposed on chronic medical illnesses are more likely to receive treatment from consultants than from primary care physicians is that they are simply a different sort of patient, because of the funneling effect of patients who receive care from specialists through physician or self-referral. On the other hand, specialists also have the luxury of spending more time with the patient, during which they may respond to subtle behavioral cues that go undetected in the brief encounters with generalists. It is this latter reason that leads me to frequently advise residents and students to

not feel in a hurry to reach closure with a patient who has vague symptoms, seems to be in distress, or who has stigmata of psychiatric illness. One or 2 early follow-up visits, during which more questions can be asked and more nonverbal behavior assessed, can lead to a much different picture of a perplexing and complex problem.

This snapshot of the way general medical patients with anxiety disorders receive care and the type of care they receive seems to fit with my personal experience, but raises several questions that cannot be answered with this methodology. Unfortunately, many financial and organizational questions are being answered with data of this type and there seems to be little support or enthusiasm by funding agencies to dig into the "messy" world of comorbidity in primary care. Unlike with the toddler's toy, one cannot simply look underneath to see how the "little creatures" are connected and why they pop up in the order they do. Until we understand how these pesky problems pop up and learn what sort of mallet we need to whack them effectively back down, we will continue to flail away at competing medical priorities as best we can.⁵

Thomas L. Schwenk, MD
University of Michigan Medical Center
Ann Arbor

REFERENCES

1. Meredith LS, Shelbourne CD, Jackson CA, Camp P, Wells KB. Treatment typically provided for comorbid anxiety disorders. *Arch Fam Med.* 1997;6:231-237.
2. Greenfield S, Rogers W, Mangotich M, Carney MF, Tarlov AR. Outcomes of patients with hypertension and non-insulin-dependent diabetes mellitus treated by different systems and specialties: results from the Medical Outcomes Study. *JAMA.* 1995;274:1436-1444.
3. Coyne JC, Schwenk TL, Fechner-Bates S. Nondetection of depression by primary care physicians reconsidered. *Gen Hosp Psychiatry.* 1995;17:3-12.
4. Coyne JC, Schwenk TL. AHCPR depression guidelines: countering misconceptions with more misconceptions? *Am Psychol.* 1995;50:452-453.
5. Klinkman MS, Valenstein M. A general approach to psychiatric problems in the primary care setting. In: Knesper D, Riba M, Schwenk T, eds. *Primary Care Psychiatry.* Philadelphia, Pa: WB Saunders Co. In press.

Clinical Pearl

For patients with heart valve replacements already receiving warfarin sodium, adding aspirin (100 mg/d) was associated with a lower rate of major systemic embolism and death but more major bleeds and bleeding episodes. (*N Engl J Med.* 1993;329:524-529.)

and coping. Stress was often produced when a conflict in values existed between the person and the work environment. When medical decisions were based on criteria set by the insurance company—rather than quality patient care, and the choices were dictated by nonphysicians—caring and control were undermined.

Stress was also created if values became manifested in unhealthy extreme ways. In patient care, phrases such as “make everyone happy” and “do it all myself” reflected an overly caring style that eventually contributed to heightened stress. The difficulties of participants with extreme caring could be related to the “well-liked” criterion of health as defined by the knowledgeable informant.

A few findings of this study were surprising. The first is the presentation of spirituality as a value and prayer as a coping strategy. Minimal attention has been directed toward spirituality in previous research on physician stress. This dimension was presented early in the interview process, reflecting its importance.

A second surprising finding concerned the level of emotionality in the interviews. There were many moments in which intense feelings were strongly expressed. This was quite different from my expectation of caution and guardedness. It could be argued that the openness of the participants was tied to their psychological health. My membership on the family medicine faculty and career as a mental health professional familiar with the culture of family medicine could also help explain this quality.

A potential limitation of this study is its reliance on interviews as the main source of research data. Subjective bias can be viewed as a possible confounding factor in interview-based studies. In this study, maximum variation sampling, identification of the sample by a knowledgeable informant, peer reviewing, and a member check procedure were qualitative strategies used to increase the credibility of the study.¹¹

Future research should expand on the directions initiated by this study. First, substantially more research should be directed toward healthy and satisfied physi-

cians. Focusing on this group can facilitate the creation of positive solutions to the stress-related difficulties inherent to the practice of medicine.

Closer attention to developmental processes would also enrich the quality of research on physician stress. Quantitative methods tend to restrict data to the specific point of time when inventories are completed, limiting the data to one specific time in the life of the research participant. The methods of this study allowed the physicians to present meaningful developmental information to be explored in future research efforts.

Accepted for publication April 17, 1996.

Reprints: Douglas M. Post, PhD, Rardin Family Practice Center, Ohio State University, 2231 N High St, Columbus, OH 43201.

REFERENCES

1. McCue JD. The effects of stress on physicians and their medical practice. *N Engl J Med.* 1982;306:458-463.
2. Colford JM, McPhee J. The ravelled sleeve of care: managing the stresses of residency training. *JAMA.* 1989;261:889-893.
3. Lewis CE, Prout DM, Chalmers EP, Leake B. How satisfying is the practice of internal medicine? a national survey. *Ann Intern Med.* 1991;114:1-5.
4. Deckard G, Meterko M, Field D. Physician burnout: an examination of personal, professional, and organizational relationships. *Med Care.* 1994;32:745-754.
5. Lemkau J, Rafferty J, Gordon R. Burnout and career-choice regret among family practice physicians in early practice. *Fam Pract Res J.* 1994;14:213-222.
6. Quill TE, Williamson PR. Healthy approaches to physician stress. *Arch Intern Med.* 1990;150:1857-1861.
7. Revicki DA, May JJ. Occupational stress, social support, and depression. *Health Psychol.* 1985;4:61-77.
8. Patton MQ. *Qualitative Evaluation and Research Methods.* Thousand Oaks, Calif: Sage Publications Inc; 1990.
9. Searight HR, Young R. Qualitative research and family systems medicine: a natural fit. *Fam Syst Med.* 1994;12:117-131.
10. Lincoln YS, Guba EG. *Naturalistic Inquiry.* Thousand Oaks, Calif: Sage Publications Inc; 1985.
11. Miles MB, Huberman AM. *Qualitative Data Analysis.* 2nd ed. Thousand Oaks, Calif: Sage Publications Inc; 1994.
12. Crabtree BF, Miller WL. *Doing Qualitative Research.* Thousand Oaks, Calif: Sage Publications Inc; 1992:93-109.

Clinical Pearl

Six problem-solving counseling sessions improved depressed patients as much as amitriptyline hydrochloride and more than placebo. (*BMJ.* 1995;310:441-445.)

tween the 2 treatment groups, 3 months after the end of the trial. Finally, we have no explanation for the higher frequency of abdominal pain and diarrhea in the experimental group. It is not known if this effect is dose-related since a single dosage was used for all patients in this trial, as suggested by the manufacturer.

CONCLUSIONS

A number of interesting conclusions can be drawn from this trial that has studied the benefits of diclofenac over rest and immobilization in the treatment of tennis elbow: (1) Diclofenac produces a significant reduction in pain when compared with a placebo. (2) Diclofenac does not produce a clinically significant improvement of grip strength or function of the involved upper limb when compared with a placebo. (3) Diclofenac does not significantly decrease the number of days missed at work, 3 months after the end of treatment. (4) There is a time-related significant improvement in pain, grip strength, and function of the upper limb that is independent of the treatment received. This improvement can only be explained in 3 ways: it can be due to a placebo effect, to cast immobilization and rest, or to the natural history of the disorder associated with rest.

Based on these findings and on the number of side effects noted during the trial, we do not recommend the use of diclofenac in the treatment of LE at the dosage prescribed in this trial. Use of a smaller dose may be worthwhile to provide analgesia in LE, but not for functional improvement. Finally, we strongly suggest the pursuit of other clinical evaluative studies on the currently used different treatments of LE.

Accepted for publication April 9, 1996.

This research was supported by grant 6605-3308-60 from the National Health and Welfare Canada, Ottawa, Ontario.

We thank Ciba-Geigy Canada, Montreal, Quebec, for providing the medication (active and placebo) and for supporting the data collection. We also thank Hélène Montpetit for secretarial support.

This trial involved the collaboration of Antonio Ciampi, PhD, the Department of Epidemiology and Biostatistics, McGill University, and of the following orthopedic surgeons and nurses from the University of Montreal, Quebec: Charles-Hilaire Rivard, MD, Constantin Stanciu, MD, and Julie Joncas, RN, Hôpital Sainte-Justine; Sylvain Gagnon, MD, Pierre Beaumont, MD, Jean-Maurice Pagé, MD, Pierre Ranger, MD, and Sylvie Robert, RN, Hôpital du Sacré-Coeur; Michel Fallaha, MD, Robert Turcotte, MD, and Andre Desjardins, MD, Hôpital Maisonneuve-Rosemont; Nicholas Newman, MD, Hôpital Hôtel-Dieu de Montréal; and Michel St-Pierre, MD, Hôpital Saint-Michel.

Corresponding author: Hubert Labelle, MD, Division of Orthopaedics, Hôpital Sainte-Justine, 3175 Chemin Côte Sainte-Catherine, Montreal, Quebec, Canada H3T 1C5.

REFERENCES

1. Adelaar RS, Maddy L, Emroch KS. Diflunisal vs naproxen in the management of mild to moderate pain associated with epicondylitis. *Adv Ther.* 1987;4:317-327.
2. Dimberg L. The prevalence and causation of tennis elbow (lateral humeral epicondylitis) in a population of workers in an engineering industry. *Ergonomics.* 1987;30:573-579.
3. Runge F. Zur Genese und Behandlung des Schreibungskampfes. *Berl Klin Wochenschr.* 1873;10:245-248.
4. Labelle H, Guibert R, Joncas J, Newman N, Fallaha M, Rivard C-H. Lack of scientific evidence for the treatment of lateral epicondylitis of the elbow. *J Bone Joint Surg Br.* 1992;74:646-651.
5. Stratford P, Levy DR, Gaudie S, Levy K, Miferi D. Extensor carpi radialis tendonitis: a validation of selected outcome measures. *Physiother Can.* 1987; 39:250-255.
6. Stratford PW, Norman GR, McIntosh JM. Generalizability of grip strength measurements in patients with tennis elbow. *Physiotherapy.* 1989;69:276-281.
7. Stratford PW, Levy DR, Gaudie S, Miferi D, Levy K. The evaluation of phonophoresis and friction massage as treatments for extensor carpi radialis tendonitis: a randomized controlled trial. *Physiother Can.* 1989;41:93-99.
8. Rosenthal M. The efficacy of flurbiprofen versus piroxicam in the treatment of acute soft tissue rheumatism. *Curr Med Res Opin.* 1984;9:304-309.
9. Saartok T, Eriksson E. Randomized trial of oral naproxen or local injection of betamethasone in lateral epicondylitis of the humerus. *Orthopedics.* 1986;9: 191-194.
10. Keller M. In: *Technical Manual Hand Strength and Dexterity Test.* Minneapolis, Minn: Sister Kenny Institute; 1977. Publication 721.

Clinical Pearl

Vitamin E supplements were associated with decreased progression of known heart disease for those patients receiving other lipid-lowering therapy ($P=.02$). (*JAMA.* 1995;273:1849-1854.)

flammation may not always be a significant component in lateral epicondylitis, many acute injuries do have significant inflammation and show notable improvement with repeated applications of ice to the injured area.⁶ Heat may also be of benefit when it is applied in chronic musculoskeletal conditions in which stiffness or soreness are the primary complaints.⁷

I applaud the pharmaceutical researchers and companies for continuing to add to our choices of treatments with medicines that offer more and more advantages, and I would certainly not want to discourage their continuing research efforts, progress, and discoveries. I encourage all primary care physicians to consider the addition of these new agents to their list of treatment options, but in their appropriate place as indicated by applicable scientific research. However, even with the newest and “flashiest” pharmaceutical drugs, don’t forget and ignore older but established therapies. The 2 therapies should be complementary, using the “older” regimens as indicated and when cost-effective, but including the “newer” treatments and medications when there is lack of progress, greater effectiveness is seen, higher patient compliance is needed with longer dosing intervals, or long-term cost-effectiveness is improved by reduced medication cost or by preventing more expensive therapies or surgery. But don’t forget—the best treatment may some-

times already be “sitting in the back of your medicine cabinet.” Mother sometimes did know best.

Douglas G. Browning, MD, ATC
Primary Care Sports Medicine
Department of Family and Community Medicine
Bowman Gray School of Medicine
Wake Forest University
Winston-Salem, NC

REFERENCES

1. Labelle H, Guibert R, for the University of Montreal Orthopaedic Research Group. Efficacy of diclofenac in lateral epicondylitis of the elbow also treated with immobilization. *Arch Fam Med*. 1997;6:257-262.
2. Day R, Seideman P. NSAIDs, musculoskeletal disorders and gastrointestinal adverse effects. *Aust Fam Physician*. 1991;20:1735-1737.
3. March L, Irwig L, Schwarz J, Simpson J, Chock C, Brooks P. n of 1 trial comparing a non-steroidal anti-inflammatory drug with paracetamol in osteoarthritis. *BMJ*. 1994;309:1041-1046.
4. Schnitzer TJ. Osteoarthritis treatment update: minimizing pain while limiting risk. *Postgrad Med*. 1993;93:89-92.
5. Schactel BP, Fillingim JM, Thoden WR, Lane AC, Baybutt RI. Sore throat pain in the evaluation of mild analgesics. *Clin Pharmacol Ther*. 1988;44:704-711.
6. Evans TA, Ingersoll C, Knight KL, Worrell T. Agility following the application of cold therapy. *J Athlet Training*. 1995;30:231-234.
7. Halvorson GA. Therapeutic heat and cold for athletic injuries. *Phys Sportsmed*. 1990;18:87-94.

Clinical Pearl

Many men who snore more than half the night do not have sleep apnea. (*Am J Respir Crit Care Med*. 1995;151:1459-1465.)

Weight loss (≥ 3 kg) improved snoring. A weight loss of 6 to 11 kg stopped snoring for a few men. (*Chest*. 1995;107:1283-1288.)

Accepted for publication May 8, 1996. We thank Caroline Sori, MA, for editing the manuscript.

Reprints: Truls Østbye, MD, MPH, Department of Epidemiology and Biostatistics, University of Western Ontario, London, Ontario, Canada N6A 5C1 (e-mail: ostbye@uwo.ca).

REFERENCES

1. Preston J, Brown PW, Hartley B. Using telemedicine to improve health in distant areas. *Hosp Community Psychiatry*. 1992;43:25-31.
2. Fritz J. Video connections. *Byte*. 1995;5:113-116.
3. Anonymous. The revolution begins, at last. *The Economist*. 1995;336(7934):15-16.
4. Branger PJ, van der Wouden JC, Schudel BR, et al. Electronic communication between providers of primary and secondary care. *BMJ*. 1992;305:1068-1070.
5. Brennan PF, Ripich S, Moore SM. The use of home-based computers to support persons living with AIDS/ARC. *J Community Health Nurs*. 1991;8:3-14.
6. Lamb AN, Boddy K, Dripps JH, de Pereira AS, Vaz F. Telemedicine, wireless communications and the provision of local community based maternity services. In: Barahona P, ed. *Medical Informatics Europe 1984: Proceeding of the 12th International Congress of the European Federation for Medical Informatics*. Berlin, Germany: Springer-Verlag; 1984.
7. Nordrum I, Engum B, Rinde E, Finseth A. Remote frozen section service: a telepathology project in Northern Norway. *Hum Pathol*. 1991;22:514-518.
8. Elion JL, Petrocelli RR. A high-speed network for cardiac image review. *Proc Annu Symp Comput Appl Med Care*. 1994;428-432.
9. Hubble JP, Pahwa R, Michalek DK, Thomas C, Koller WC. Interactive video conferencing: a means of providing interim care to Parkinson's disease patients. *Mov Disord*. 1993;8:380-382.
10. Farman AG, Farag AA. Teleradiology for dentistry. *Dent Clin North Am*. 1993;37:669-681.
11. Rayman RB. Telemedicine: military applications. *Aviat Space Environ Med*. 1992;53:135-137.
12. Wright R, Loughrey C. Teleradiology. *BMJ*. 1995;310:1392-1393.
13. Rinde E, Nordrum I, Nymo BJ. Telemedicine in rural Norway. *World Health Forum*. 1993;14:71-77.
14. Ling R. Telemedicine: treating the patient by remote control. *J R Nav Med Serv*. 1993;79:145-147.
15. Yellowlees P, McCoy WT. Telemedicine: a health care system to help Australians. *Med J Aust*. 1993;159:437-438.
16. Hostetler S. Lower end technology may eventually dominate. *Telemedicine*. 1994;1:17-18.
17. Ellenberger B. Navigating physician resources on the Internet. *Can Med Assoc J*. 1995;152:1303-1307.
18. Shortliffe EH. The adolescence of AI in medicine: will the field come of age in the '90s? *Artif Intell Med*. 1993;5:93-116.
19. Goldberg MA, Sharif HS, Rosenthal DI, et al. Making global telemedicine practical and affordable: demonstrations from the Middle East. *AJR Am J Roentgenol*. 1994;163:1495-1500.
20. Frame PS. Computerized health maintenance tracking systems: a clinician's guide to necessary and optional features. *J Am Board Fam Pract*. 1995;8:221-229.
21. Isabelle P, ed. *Translation Analysis and Translation Automation: Proceedings of the Fifth International Conference on Theoretical and Methodological Issues in Machine Translation*; Kyoto, 1993. Laval, Quebec: Centre for Information Technology Innovation; 1993.
22. Sutherland LR, Verhoef MJ. Why do patients seek a second opinion or alternative medicine? *J Clin Gastroenterol*. 1994;19:194-197.
23. Fisher P, Ward A. Complementary medicine in Europe. *BMJ*. 1994;309:107-111.
24. Internet distributes child porn from an address in Helsinki. *Helsingin Sanomat*. February 7, 1995;1.
25. Simpson M, Buckman R, Stewart M, et al. Doctor-patient communication: the Toronto consensus statement. *BMJ*. 1991;303:1385-1387.
26. Baroness JA. The GPEP report, II: clinical education. *Ann Intern Med*. 1985;103:286-288.
27. Nadeau M. Not lost in space. *Byte*. 1995;6:50-54.
28. Bergman R. Letting telemedicine do the walking. *Hosp Health Netw*. 1993;10:47-48.
29. Anonymous. Net profits. *The Economist*. July 1, 1995;336:12S-14S.
30. Singleton A. Cash on the wirehead. *Byte*. 1995;6:71-78.
31. Gill D. European boards and colleges: euro-pæds or urophobia? *Lancet*. 1992;339:1216-1217.
32. Goldman RL. The reliability of peer assessments of quality of care. *JAMA*. 1992;267:958-960.
33. McAuley RG, Paul WM, Morrison GH, Beckett RF, Goldsmith CH. Five-year results of the peer assessment program of the College of Physicians and Surgeons of Ontario. *Can Med Assoc J*. 1990;143:1193-1199.
34. The Canadian Task Force on the Periodic Health Examination. *The Canadian Guide to Clinical Preventive Health Care*. Ottawa, Ontario: Health Canada; 1994.
35. Ferrell BG. Clinical performance assessment using standardized patients: a primer. *Fam Med*. 1995;27:14-19.
36. Frisse ME. The health of the computer-based medical record. *Acad Med*. 1992;67:441-443.
37. Rector AL, Nowlan WA, Kay S. Foundations for an electronic medical record. *Methods Inf Med*. 1991;30:179-186.
38. Bryan J. Compression scorecard. *Byte*. 1995;5:107-111.
39. Anonymous. Medical records: the privacy conundrum. *The Economist*. April 29, 1995;336:96-97.
40. Norton SA, Lindborg CE, Delaplain CB. Consent and privacy in telemedicine. *Hawaii Med J*. 1993;52:340-341.
41. Akselsen S, Lillehaug S. Teaching and learning aspects of remote medical consultation. *Teletronik*. 1993;89:42-47.

Clinical Pearl

Erythromycin (250 mg 3 times daily for 3 weeks) was associated with faster gastric emptying time and lower symptom score than metoclopramide hydrochloride (10 mg 3 times daily). (*Diabetes Care*. 1993;16:1511-1514.)

sicians are in a position to provide the information and education required to help limit the transmission of HIV. Primary care physicians should inquire about HIV risk factors (by obtaining a complete sexual history, a history of sexually transmitted diseases, information about sexual orientation, a history of intravenous drug use, and a history of blood transfusions) in all patients, regardless of age, and should counsel patients about effective HIV prevention strategies.

Accepted for publication March 20, 1996.

Presented in part at the 35th Interscience Conference of Antibiotic Agents and Chemotherapy, San Francisco, Calif, September 18, 1995.

We thank Justin Radolf, MD, for his thoughtful review of the manuscript.

Reprints: Daniel J. Skiest, MD, Division of Infectious Diseases, University of Texas Southwestern Medical Center, 5323 Harry Hines Blvd, Dallas, TX 75235-9113 (e-mail: skiest@utsw.swmed.edu).

REFERENCES

1. HIV/AIDS Surveillance Report. Atlanta, Ga: Centers for Disease Control and Prevention; 1995;7:1-34.
2. AIDS: An Expanding Tragedy: The Final Report of the National Commission on AIDS. Washington, DC: National Commission on AIDS; 1993.
3. Stall R, Catania J. AIDS risk behaviors among late middle-aged and elderly Americans. *Arch Intern Med.* 1994;154:57-63.
4. Gerbert B, Maguire BT, Coates TJ. Are patients talking to their physicians about AIDS? *Am J Public Health.* 1990;80:467-468.
5. Porter K, Wall PG, Evans BG. Factors associated with lack of awareness of HIV infection before diagnosis of AIDS. *BMJ.* 1993;307:20-23.
6. Ferro S, Salit IE. HIV infection in patients over 55 years of age. *J AIDS.* 1992; 5:348-355.
7. El-Sadr W, Gettler J. Unrecognized human immunodeficiency virus infection in the elderly. *Arch Intern Med.* 1995;155:184-186.
8. US Public Health Service. *Healthy People 2000.* Hyattsville, Md: US Dept of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention; 1991.
9. Fredman L, Rabin DL, Bowman M, et al. Primary care physicians' assessment and prevention of HIV infection. *Am J Prev Med.* 1989;5:188-195.
10. 1991 Population Estimates. Arlington, Tex: North Central Texas Council of Governments, Regional Data Center; 1991.
11. HIV/AIDS Surveillance Report. Atlanta, Ga: Centers for Disease Control and Prevention; 1994;5:1-29.
12. Feldman MD. Sex, AIDS, and the elderly. *Arch Intern Med.* 1994;154:19-20.
13. Gerbert B, Bleeker T, Maguire B, Caspers N. Physicians and AIDS: sexual risk assessment of patients and willingness to treat HIV-infected patients. *Arch Intern Med.* 1992;7:657-664.
14. Hu DJ, Byers R, Fleming PL, Ward JW. Characteristics of persons with late AIDS diagnosis in the United States. *Am J Prev Med.* 1995;11:114-119.
15. Skiest D, Rubinstien E, Carley N, Gioiella L, Lyons R. The importance of comorbidity in HIV infected patients over 55: a retrospective case-control study. *Am J Med.* 1996;101:605-611.
16. Gemson DH, Colombotos J, Elinson J, Fordyce J, Hynes M, Stoneburner R. Acquired immunodeficiency syndrome prevention: knowledges, attitudes, and practices of primary care physicians. *Arch Intern Med.* 1991;151:1102-1108.
17. Pfeiffer E, Verwoerd A, Davis GC. Sexual behavior in middle life. *Am J Psychiatry.* 1972;128:1262-1267.
18. Michael R, Laumann E, Gagnon J, Smith T. Number of sex partners and potential risk of sexual exposure to HIV. *MMWR Morb Mortal Wkly Rep.* 1988; 37:565-568.
19. Berger RM. *Gay and Gray.* Urbana: University of Illinois; 1982.
20. Loft J, Marder W, Bresolin L, Rinaldi R. HIV prevention practices of primary-care physicians: United States, 1992. *MMWR Morb Mortal Wkly Rep.* 1994; 42:988-992.
21. Makadon HJ, Silin JG. Prevention of HIV infection in primary care: current practices, future possibilities. *Ann Intern Med.* 1995;123:715-719.
22. Shappert SM. National Ambulatory Medical Care Survey: 1989 summary: National Center for Health Statistics. *Vital Health Stat 13.* 1992;110.
23. Hayward RS, Steinberg EP, Ford DE, Roizen MF, Roach KW. Preventive care guidelines: 1991. *Ann Intern Med.* 1991;114:758-783.
24. Gordon SM, Thompson S. The changing epidemiology of human immunodeficiency virus infection in older persons. *J Am Geriatr Soc.* 1995;43:7-9.

Clinical Pearl

Below-the-knee elastic stockings objectively improved diabetic microangiopathy. (*J Cardiovasc Surg.* 1993;34:479-482.)

plication developed from their desire to give nurses an effective way to interact with infants and families in an educational and interventional manner in the early postpartum period. Munck addresses the strength of the NBAS as a psychotherapeutic approach in the face of a particularly vulnerable parent-child unit. Her clinical vignettes demonstrate the value of interpreting an infant's behavior for a parent and of demonstrating the infant's innate strengths. She shows parents ways to recognize signs of stress in their infant and to decrease the environmental toll on their vulnerable child. Cardone and Gilkerson describe a specialized adaptation of the scale called "Family Administered Neonatal Activities." Their goal is to empower families in their model; the parents are instructed by a facilitator to perform the NBAS

items and to comment on and interpret their observations of their infant and themselves. This information is reflected and interpreted by the facilitator in an instructive and therapeutic manner. Cole addresses the use of the NBAS with high-risk neonates. Such infants are accurately perceived as more fragile and less accessible by their caregivers and their families. This application sensitizes parents and caregivers to infants' cues, to their tolerance levels, and to an appreciation of their neurophysiological progress.

Thus, the *Neonatal Behavioral Assessment Scale, Third Edition*, is a manual that includes rigorous research methods and a wide variety of clinical applications. Addressing the entire spectrum in this compact volume effectively gives the primary care clinician information at whatever

depth is desired, from the most precise guidelines for test administration and scoring, to the philosophy and many clinical uses of the scale. The narrative descriptions of the test and the many sections on clinical applications and case vignettes are informative and compelling. I highly recommend this book to any member of a health care team who routinely works with neonates and families. It provides a concise, well-organized, accessible clinical tool for enhancing the counseling of normal and at-risk newborns and their families and will greatly increase the practitioner's appreciation for the complex abilities of the newborn.

Esther Entin, MD
Department of Family Medicine
Brown University
School of Medicine
Providence, RI

Consult the Archives to Stay Ahead in Your Specialty



Peer-reviewed, primary source journals are a physician's best information resource. And the Archives journals, from the world's largest publisher of original, scientific information, are the best choice available to gain fresh insights and keep up with the latest advances.

Call toll-free 800-AMA-2350 or fax 312-464-5831 for subscription information.

E-mail: ama-sub@ama-assn.org

Stay at the forefront
of medicine.
Subscribe today!

P7FA3

A UNIQUE HEMODYNAMIC AND SAFETY PROFILE DIFFERENT FROM DIHYDROPYRIDINES

Benefits of a
nondihydropyridine CCB*

Effective 24-hour control of hypertension or angina

- Reduces blood pressure with no reflex tachycardia¹
- Increases exercise tolerance, reduces vasospasm, and decreases heart rate in angina¹

Well-tolerated control regardless of age or gender[†]

- A side-effect discontinuation rate comparable to placebo^{2,3}
- Most commonly reported side effects are headache (5.4%), bradycardia (3.3%), first-degree AV block (3.3%), dizziness (3.0%), edema (2.6%), ECG abnormality (1.6%), and asthenia (1.8%)¹

True 24-hour control from a unique patented delivery system

- No other diltiazem is therapeutically equivalent to Cardizem CD^{4†}

*Cardizem CD is a benzothiazepine calcium channel blocker.

† In clinical trials with Cardizem CD.

‡ FDA does not, at this time, consider other diltiazems to be therapeutically equivalent because bioequivalence has not been demonstrated through appropriate studies.

Please see brief summary of prescribing information on adjacent page.

FOR HYPERTENSION OR ANGINA



ONCE - A - DAY

CARDIZEM[®] CD

(diltiazem HCl) 120-, 180-, 240-, 300-mg Capsules

No other diltiazem is therapeutically equivalent^{4†}