Medical Care among Strangers

To the Editor: Dr. G. Gayle Stephens's well-written editorial (July-September 1988) strikes home in many ways; however, one of the best things about being a "gate-keeper" is being able to convince people that now they may not need all of the technical nuances that they think they need. I truly believe that a form of collusion exists between the patient and the physician to provide a lot of unnecessary, i.e., not useful, care, considering the costs and the benefit. As Paul Starr pointed out in his book, *The Social Transformation of American Medicine* (New York: Basic Books, Inc. 1982), it is the medical community that fails to recognize that it is society that decides what its needs and expectations are, not the physician. Our responsibility is to be sure that, in society's decisions, we, as physicians, implement the best and most efficient care to meet those needs.

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Empiricism in Family Practice

To the Editor: Dr. Paul Young's observations on empiricism in medicine[1] shed welcome light on an area of scholarly endeavor that has fallen into undeserved disrepute—the analysis of one's personal clinical experiences as a starting point for scientific investigation and, when necessary, as a basis for patient care. In an ideal world, all medical treatment would be based on scientific studies, but in reality there are many aspects of health care where solid, unassailable information does not exist. Much of today's clinical research is devoted to creating a firm objective foundation for patient care, but until it bears fruit, physicians must often act—or elect not to act—on the basis of tradition, hunch, and empirical observation. In doing so, they must accept the fact that, with the passage of time, their presumptive observations may face either rejection or vindication.

An example of the former is the use of oral antihistamine-decongestant products in the treatment of otitis media with effusion, a practice that had theoretical attractiveness but could not be shown, in a double-blind trial, to be effective.[2] On the other hand, the treatment of urethritis with tetracycline and related agents was advocated on purely empirical grounds long before the clinical importance of chlamydia and other tetracycline-sensitive microorganisms was recognized.[3,4]

Empiricism has necessarily played a major role in the psychosocial aspects of health care because many of the conditions one would like to study are inherently imprecise, difficult to measure, and slow to change in response to intervention. There are, understandably, few double-blind controlled studies, other than drug trials, on the diagnosis and management of most behavioral problems. We remain optimistic, however, that many family medicine tenets will eventually be supported at the $P = 0.05$ level.

In my view, Dr. Young's essay points up the importance of being honest about what we do and don't know. With one patient our position may be, "I don't know enough to help, and the risk of adverse outcome is high enough that it's best not to meddle." For another, it may be, "I can probably help this person, and my risk of being wrong is, on balance, acceptably low." We expect that as our knowledge expands we will be able to say, with increasing frequency, "There is solid scientific evidence to support a firm diagnosis and a clearly beneficial form of treatment for this patient." However, we cannot stop caring for patients until this happens.

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3. Hoffman WW. Demethylchlortetracycline in the management of urological infections. J Urol 1970; 104:578-80.
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Nuchal Cord

To the Editor: The case report regarding nuchal cord by Drs. Grimm and Cable (July–September 1988) describes a phenomenon I believe to be fairly common. During the past 12 years we have had 1 or 2 babies of the 35 to 40 delivered in our hospital monthly with facial edema and/or facial "bruising" as a result of a nuchal cord. I agree that most of these babies have at least some variable deceleration during the second stage of labor but have Apgars of 7 or higher for 1 and 5 minutes.

I do feel that the case report does raise several important issues. First, shouldn't truncal rather than facial skin color be used in the Apgar score? The authors comment that severe discoloration (facial?) from venous congestion was responsible for a lowered score. Second, not all of the decelerations seen during "pushing" meet the definition for fetal distress (with or without a nuchal cord). We must be careful when using the term "fetal distress" in this situation. Third, in this day of birthing rooms when mothers hold their swaddled baby immediately after delivery, might an inexperienced person assume the baby with only the discolored face showing to be a candidate for unnecessary oxygen and resuscitation?

This *Journal* provides an excellent forum for family physicians to present their clinical observations and to allow others to comment on their observations. Thank you for undertaking the arduous task of its publication.

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