

We will try to publish authors' responses in the same edition with readers' comments. Time constraints may prevent this in some cases. The problem is compounded in the case of a bimonthly journal where continuity of comment and redress is difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Limits of Technology

To the Editor: Could the riddle be the truth and is the parable irony? In the September-October issue of *JABFP*, Dr. Gayle Stephens writes a thought-provoking piece on the ultimate limits of technology as it consumes even itself and its opponents (Primary Medical Care: A Riddle and a Parable. *J Am Board Fam Pract* 1992; 5:540-1). At the same time, McBride and colleagues have a juxtaposed editorial about the utility of ambulatory blood pressure monitoring as a new technology in which, "Initial purchase costs of equipment and software are \$7,000 to \$10,000, and typical charges are \$200 to \$300 for a monitored session."^{p 542}

One of the great ironies of family medicine is our ability to describe accurately the problems confronting medical reform at the same time that we are fascinated by the advances in technology that are directly applicable to our specialty. While ambulatory blood pressure monitoring might indeed one day save costs and lives and improve the quality of those still living, such benefits remain to be proved. Until such time, the benefits to widespread use of this technology might benefit physicians more than society. We need to be careful about feeding the "red bull" in our own backyards.

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Ambulatory Blood Pressure Monitoring

To the Editor: The article by Drs. Ferguson and Shaar in the September-October 1992 issue of *JABFP* (The Effective Diagnosis and Treatment of Hypertension by the Primary Care Physician: Impact of Ambulatory Blood Pressure Monitoring. *J Am Board Fam Pract* 1992; 5:457-65) was certainly important in demonstrating the usefulness of the ambulatory blood pressure monitor. There are, however, some additional points that should be made about the special need fulfilled by ambulatory blood pressure monitoring.

Because many family physicians provide some element of industrial or occupational medicine in their practice, they are often called on to do Department

of Transportation (DOT) physical examinations for truck drivers. There has always been a standard that blood pressure values greater than 160/90 mmHg require special assessment, and they can entirely disqualify the particular driver. It has been our impression, and we have been able to demonstrate it clinically, that certain groups of truck drivers are so concerned about their blood pressure and their ability to make a living that their normal blood pressure becomes elevated — a variant of the classic "white coat" hypertension. We have used ambulatory monitoring to reduce the level of concern for such patients and to qualify them for being able to drive a DOT vehicle.

Special consideration should also be given to using ambulatory blood pressure monitoring when evaluating commercial pilots, because their livelihood might also depend on the ability to control their blood pressure with limited amounts of medication. The proper diagnosis of hypertension or inappropriate use of medication could certainly be a major problem for either of these two patient categories.

I appreciate the practical approach that the *Journal* seems to be taking toward primary care and look forward to each issue.

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Pseudoephedrine in Pregnancy

To the Editor: Anastasio and Harston, in their article on the fetal effects of pseudoephedrine taken by the pregnant woman,¹ have cited and perhaps relied upon an old (1982) textbook reference, which claimed that this drug was "considered safe in pregnancy." Pseudoephedrine has been assigned a risk factor rating of C in a newer summary of drugs,² a rating moderately far from the safe classification, and one that bears a warning that drugs ranked there should be given only if the benefit justifies potential risk to the fetus, which is not known for drugs with this rating.

The assertion that any drug is safe for a pregnant woman is becoming more and more difficult in the face of increasing knowledge of subtle and late-appearing ill effects from many apparently "safe" substances, as the article itself well points out. *Williams Obstetrics*³ summarizes general guidelines for use of drugs in women who are or may be pregnant, advising that any drug that exerts a systemic effect on the mother will cross the placenta and that any advantages of such "must clearly outweigh any risks inherent in its use."

Family practice training centers should take care that reference materials represent the most up-to-date knowledge available.

Thomas W. Filardo, MD
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References

1. Anastasio GD, Harston PR. Fetal tachycardia associated with maternal use of pseudoephedrine, an over-the-counter oral decongestant. *J Am Board Fam Pract* 1992; 5:527-8.
2. Briggs GG, Freeman RK, Yaffe SJ. *Drugs in pregnancy and lactation*. 3rd ed. Baltimore: Williams & Wilkins, 1990.
3. Pritchard JA, MacDonald PC, Gant NF. *Williams obstetrics*. 17th ed. Norwalk: Appleton-Century-Crofts, 1985.

The above letter was referred to the authors of the article in question, who offer the following reply:

To the Editor: We thank Dr. Filardo for bringing to our attention a new and well-referenced text entitled *Drugs in Pregnancy and Lactation*¹ by Briggs and colleagues. This reference was published in 1990 and therefore not available in 1989, when the case we reported occurred.

The Food and Drug Administration (FDA) pregnancy categories were established in 1979 and rank a drug on its ability to cause risk to the fetus. Pseudoephedrine was approved for use prior to 1979 and therefore does not have an FDA pregnancy category rating. Briggs, Freeman, and Yaffe¹ have assigned pseudoephedrine to category C. The most recent edition of *Williams Obstetrics*² gives this description of category C drugs:

Drugs for which there are no adequate studies, either animal or human, or drugs in which there are adverse fetal effects in animals studies but no available human data. Many drugs or medications commonly taken during pregnancy are in this category; therefore, it presents the most difficulty for the physician both with respect to clinical use and from a medicolegal standpoint.

Neither reference cited by Dr. Filardo states a concern for using pseudoephedrine in the third trimester. Briggs, et al.¹ state that an association in the first trimester was found between the sympathomimetic class of drugs as a whole and minor malformations. *Williams Obstetrics* states, "Most antihistamines and decongestants are classified as categories B or C, and while they are apparently harmless, they should be avoided, at least in early pregnancy." Historically, data on the risk of drugs in pregnancy focused on the teratogenic effects that occur during the first trimester. More data need to be obtained concerning the pharmacologic and physiologic effects of maternal use of drugs on the developed fetus.

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References

1. Briggs GG, Freeman RK, Yaffe SJ. *Drugs in pregnancy and lactation*. 3rd ed. Baltimore: Williams & Wilkins, 1990.

2. Cunningham FG, MacDonald PC, Grant NF. *Williams obstetrics*. 18th ed. Norwalk, CT: Appleton & Lange, 1989.

Microskills Model of Clinical Teaching

To the Editor: Neher, Gordon, Meyer, and Stevens reported in the July-August issue of *JABFP* their experience with a microskills model of clinical teaching in presentations to faculty in family practice and other specialties at several national and regional meetings and to fellows in family medicine.¹ We would like to report our experience in instructing medical student preceptors and 3rd-year residents in family medicine in the use of these microskills in clinical teaching.

In the last 2 years we have presented a workshop entitled Teaching Skills for the Physician: The One-Minute Preceptor at three continuing medical education courses for family physicians, three annual meetings of state academies of family practice in the Northwest region, and on two occasions to 6 graduating family practice residents. At each of the state and continuing education meetings, 20 to 30 family physicians, the majority of whom have been engaged in teaching medical students or residents, attended the presentations. The session usually occurred in a 1½-hour to 2-hour format and included an overview of the microskills, a more in-depth description of the microskills, an opportunity to practice each microskill individually in a demonstration, and, finally, small-group role playing simulating the clinical teaching environment. We utilized materials prepared by Katherine Gordon. In all cases the content of the workshop was rated at least a four on a five-point scale. Seasoned clinical teachers of medical students and residents often commented that the presentation finally made sense of what they were attempting to do in clinical teaching and that they wished they had learned the microskills earlier. Graduating 3rd-year residents have said that the model would have made teaching younger residents a less frustrating experience and would have given them an increased sense of confidence in their teaching skills. Interestingly, they believed that learning the microskills even during their 1st year would have facilitated their learning during residency by helping them to know what to expect from the clinical teaching environment.

We have found that preceptors do not believe that students formulate an opinion very early when seeing a patient. It is often enlightening to these preceptors to learn that research in medical education has shown that even the beginning student or the novice forms at least a rudimentary differential diagnosis within minutes of meeting a patient.

We often begin our presentations with a discussion of how to balance the dual roles of teacher and physician. The metaphor of two hats, in which one hat is the teacher's hat and the other is the physician's hat, has been useful. We encourage our preceptors not to try to wear both hats at one time because of the potential conflicts in agendas involved. Rather, the pre-