Correspondence

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.

Diversity in Family Practice

To the Editor: After reading Dr. Scherger's essay "Models of Family Practice" (J Am Board Fam Pract 1992; 6:649-53), I want to say how refreshing it is to hear a voice for tolerance within medicine. It is not a virtue I see demonstrated very often.

Encouraging the embrace of difference and diversity in family practice will, in the end, make the specialty stronger and more able to address the enormous health care needs that face us in this country today. Meeting needs is what I sincerely hope is the reason we family physicians are doing what we're doing! It is what keeps me going this first year of residency, rather than bailing out for something easier!

Carol Castillo, MD
Stanislaus Medical Center
Modesto, CA

Microcomputer-Based Records

To the Editor: The microcomputer-based medical record system described by Dr. Ornstein and colleagues (J Am Board Fam Pract 1993; 6:55-60) is comprehensive, expensive, and impractical for the ordinary family physician. I wonder what educational value the residents gain as they adjust to their diverse practices after this experience.

I have computerized my records merely by using an ordinary notebook computer and entering my dictations with a data base manager rather than a word processor. Consequently, all my medical dictation is stored and can be searched in a single data base file, and all individual names, dates, diagnoses, medication lists, full records, etc., can be independently retrieved. Although I have not developed a prompt system for routine health screening and patient reminders, a simple query of the data base would accomplish this. The advantage of my system is that it is cheap (less than $1500), and it is portable: all my records are with me whenever and wherever I travel.

The residency system has one particular feature that makes it a near impossibility for the private office. A paperless office requires that laboratory and radiology reports be downloaded directly through the computer, which is not possible for most private physicians. I enter all my pertinent data by dictation. Another disadvantage of the paperless office is that browsing through medical records is much slower on the computer screen than through a chart. The eye can scan a page and glean details quicker, in my opinion and experience, from the paper copy. It would be interesting for the authors to report how much actual paper copy they do generate in the clinic and then subsequently discard. It might be substantial.

Steven A. Meyer, MD
Fruitland Park, FL

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

To the Editor: We are pleased that Dr. Meyer appreciates the benefit of computerized patient records (CPRs) and has incorporated a system in his practice. The software described in our report[1] can also run on a notebook computer, costs only $2000 if used in this fashion, and includes the important health maintenance prompting and reminder system.

Our residency graduates generally are advocates of CPRs and work to educate their practice partners about the benefits of these systems. They play a major role in CPR dissemination efforts, an important function described in the recent Institute of Medicine report.[2] Because we adopted our current CPR system less than 2 years ago, it is too early to draw conclusions about the success of their advocacy efforts.

Dr. Meyer is correct in asserting that special arrangements must be made by practicing physicians to transfer information electronically from laboratory and radiology facilities. The feasibility of this interface has been documented by several users of the software we described. He is also correct in stating that most physicians find it slightly faster to read text from paper than on a computer screen. The computer, however, is much faster at several other vital clinical functions, such as retrieving specific notes, displaying trends in laboratory data and abnormal values, and searching for needed health maintenance items and drug interactions. The dramatic advantages of CPRs are obvious to most physicians who have used them, apparently including Dr. Meyer, who has incorporated a basic system in his office.

Steven M. Ornstein, MD
David R. Garr, MD
Ruth G. Jenkins, MS
Charleston, SC

References

1. Ornstein SM, Garr DR, Jenkins RG. A comprehensive microcomputer-based medical records system with sophis-

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ticated preventive services features for the family physician. J Am Board Fam Pract 1993; 6:55-60.
2. Dick RS, Steen EB, editors. The computer-based patient record: an essential technology for health care. Report of a study by a committee of the Institute of Medicine. Washington, DC: National Academy Press, 1991.

Headache after Lumbar Puncture

To the Editor: I read the recent article "Chronic Headaches in Family Practice" by Robert Smith.[1] I have had 5 years experience in family practice before beginning my anesthesia training, which gives me a somewhat unique point of view. While the article was very informative, I would like to point out some incorrect information that appeared on p. 594 concerning postlumbar puncture headache.

While it is correct that lower cerebral spinal fluid (CSF) pressure is believed to be the cause of the headache and that the hallmark of a postdural puncture headache is relief when the patient lies flat, the information about a blood patch is incorrect.

If a postdural puncture headache lasts 24 to 48 hours and fails to respond to intravenous hydration and caffeine, then the treatment of choice is an epidural blood patch. Ten to 20 mL of the patient's whole blood is aseptically injected into the *epidural* space at a vertebral interspace as close as possible to the previous dural puncture. The blood is injected slowly with the end point of headache relief or 20 mL. This is effective 90 percent of the time.[2]

The blood patch works by forming a clot on the *outer* surface of the dura and blocking the leak of CSF. This action prevents the lowered CSF pressure and hence the headache resolves. No further subarachnoid injections are needed, as was stated in the article.

Rodger Orman, MD
St. Joseph's Hospital
Syracuse, NY

References

1. Smith R. Chronic headaches in family practice. J Am Board Fam Pract 1992; 6:589-99.
2. Barash, Paul G. Cullen BF, Stoelting RK. Clinical anesthesia. Philadelphia: Lippincott, 1989:778-80.

The preceding letter was referred to the author of the article in question, who responds as follows:

To the Editor: Thanks to Dr. Orman for his informative letter. His expanded description of the postlumbar headache treatment method makes a useful addition to my recent article. He rightly corrects my account of the mechanism of the blood patch by pointing out that the injection is made into the epidural, not into the subarachnoid space. It is good to be corrected on a matter such as this by a family physician.

Robert Smith, MD
University of Cincinnati
Cincinnati, OH

Single-Payer System

To the Editor: Dr. Howard Brody's editorial on the American Academy of Family Physicians' plan for addressing current problems with health care in the United States[1] is on the mark in most respects, but the author's assessment of the benefits to be derived from switching to a single-payer system appear unduly optimistic.

As the editorial states, the much-touted figure of $50 billion in annual savings would require not only the adoption of a single-payer system but also a program of global budgets for health care institutions. In effect, the government would negotiate (while holding the purse strings) how much it would pay each hospital or other health care facility for a year's services. Each institution would be forced to survive, if possible, on its allotment. This outcome is not inevitably bad and it might be unavoidable,[2] but it would be stressful for administrators, professionals, staffs, and probably also for patients, and it could have a considerable adverse impact on quality of care.

The much-quoted Woolhandler and Himmelstein article[3] has been largely discredited by subsequent analysis in the same journal's "Letters"[4] and elsewhere.[5] The article reflected a diligent effort to compare costs under the present US and Canadian systems but foundered on discrepancies in what was measured and on multiple, sometimes unquantifiable differences in the two nations' health delivery systems. The latter include the level of entrepreneurial activity by physicians, the impact of a "medical-industrial complex" on decision making, the expectations of patients, and the proportion of physicians doing primary care.

As noted by Ginzberg[2] and others, recent and projected increases in medical spending in the United States are of such magnitude that no viable scheme in our present political climate is likely to bring about the required cost savings. Wennberg[6] asserts that the necessary economies could be derived from making our system more rational (in his context, by persuading Boston physicians to practice as economically as those in New Haven), but changes in medical practices and standards of this magnitude could require decades, even with strong persuasion from third-party payers.

To underscore the enormity of the crisis, consider that an annual saving of $50 billion, even if it could be achieved, would be swallowed up within a year by the relentless increase in health care costs, which have continued to expand at two to three times the inflation rate despite diverse and increasingly powerful attempts to contain them. Dr. Brody is correct in asserting that the AAFP proposal falls short of what is needed, but any plan Draconian enough to address the problem adequately would, in the present climate of US public and professional opinion, be politically nonviable.

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