Tem seems to me to provide the sort of framework
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payer system. Whatever we do will have serious draw­
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form in the United States. What are physicians to do
and the status quo is both ethically and economically

References
1. Brody H. The AAFP access plan: getting it almost right.
2. Ginzberg E. Health care reform — where are we and
3. Woolhandler S, Himmelstein DU. The deteriorating
administrative efficiency of the US health care system.
5. Gauthier AK, Rogal DL, Barrand NL, Cohen AB. Adminis­
trative costs in the US health care system: the problem or
6. Wennberg JE. Outcomes research, cost containment, and
332:1202-4.

To the Editor: I would like to comment in reference
to the editorial in the November-December 1992
issue entitled “The AAFP Access Plan: Getting It Al­
most Right” by Howard Brody. Dr. Brody contends
that health care in the United States is a “nonsys­
He relates that it is administratively inefficient and
drives up costs two ways: “First, more employees are
needed to process all the different payers. Second,
more employees are needed to track each item of
care and supplies dispensed . . . .”

Certainly, few physicians in private practice would
argue that a more simplified system is needed. How­
ever, Dr. Brody’s solution to this administrative waste
is a single-payer system. A single-payer system, I as­
sume, would be the government, or more specifically
the federal government. He further contends that the
o administrative efficiency of the

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Dr. Brody notes a number of obstacles
to the implementation of substantial health care re­
form in the United States. What are physicians to do
when truly basic reform seems “politically nonviable”
and the status quo is both ethically and economically
nonviable? I argue that we ought to see what can be
done to marshall political support behind a single­
payer system. Whatever we do will have serious draw­
backs in its implementation phase. A single-payer sys­
tem seems to me to provide the sort of framework
that will allow the drawbacks to be sorted out quickly
and to allow physicians who care about patients’ con­
cerns to champion quality of care most effectively.

A brief form of Dr. Jacobson’s comment might be,
“If you like the Post Office, you’ll love national
health insurance.” We should first recall, however,
that a single-payer system need not necessarily be a
government-administered system; there are numer­
ous alternative models. Second, the facts about gov­
ernment waste and inefficiency might not square with
our natural prejudices — for instance, why does the
US Social Security System pay 5 percent for admin­
istrative overhead while the average private health in­
surance company pays 15 percent?

Howard Brody, MD
Michigan State University
East Lansing

Newsletters in Family Practice
To the Editor: I wish to compliment Dr. Shaughnessy
and colleagues on their important original contribu­
tion to the continuing education of family physicians,
“Survey and Evaluation of Newsletters Marketed to
Family Physicians,”1 which was objective, balanced,
and fair.

The authors evaluated eight newsletters and sum­
m peeled their data in helpful graphs. What was miss­
ing, however, was any elaboration of the subjective
differences in these newsletters, which are large and
important.

Questions that readers will have include the fol­
lowing: is the content directly relevant to office prac­
tice? Is the style readable and engaging? Is the point
view that of a generalist or a specialist? The most
important question is whether there is a consistent
philosophy of medical care and practice presented or
are the chosen abstracts supposed to represent a
value-neutral smorgasbord of noteworthy recent lit­
erate? The studies that are left out of these news­
letters are as important as what is included. These
choices are not random and are worth considering;
they should be made explicit. For the record, I would
like to state mine.

My goal in presenting The Family Practice Newsletter
is to identify, synthesize, and persuade. I present my
data from the perspective of an individual, practicing,
generalist physician who is looking at a large amount
of expert information both from peers and from spe­
cialists in other fields. I convey the personal dilemmas
I have faced in trying to scan a too voluminous
literature, in trying to extract the small amount that
can and should become familiar to practicing physi­
cians, and in trying to incorporate these individual
pieces of data into a coherent, systematic, and value­
laden framework.

Two central biases permeate all of my work — that
the practice of medicine should make sense to the
practitioner and that the appropriate response to
modern information overload is strategic learning (as
through newsletters) and strategic practice. Strategic
practice consists in focusing, first, on the most prevalent determinants of morbidity and mortality in a community; second, on the 10 most common reasons for office visits to physicians (what we do most often we ought to do well); and third, on the diagnostic imperatives\(^2\) of family practice (all conditions that are treatable merit higher priority than all those conditions, however serious, that are not).

Medicine should make sense, and when too much information is presented and distilled by too many experts, the message becomes either fuzzy or frankly contradictory. There are many areas in which either there are simply inadequate data (as pointed out so frequently in the conclusions of the US Preventive Services Task Force Report\(^3\)) or where the experts disagree. Yet family physicians have to act and make the best they can of the existing data. I believe my newsletter is currently unique in presenting for public commentary and feedback a family physician’s personal synthesis, justification, and recommendation of a footpath to take through the woods until expert consensus opens the highway.

Sidney Gellis was the first to offer such a personalized guide through the medical literature maze for practicing pediatricians with his *Pediatric Notes*.\(^4\) While there have been many other newsletters, both in pediatrics and family practice, none of the others has elected this personalized approach. This characteristic was acknowledged in the Shaughnessy, et al. review, but not analyzed further. What a reader is choosing in a newsletter is not specific content but rather the editor’s judgment, sense, and biases as a proxy or adjunct to the reader’s own. Does the personalized relationship with a critically chosen representative make a difference in outcomes in practice? No one knows. I believe that it does, but I leave it to future high-quality work by Shaughnessy and others to provide us with the answer.

Colin P. Kerr, MD, JD, MPH

*The Family Practice Newsletter*

Mount Gretna, PA

References

4. Pediatric Notes. Newtonville, MA.