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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 Almost Right" by Howard Brody. Dr. Brody contends that health care in the United States is a "nonsystem." 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. However, Dr. Brody's solution to this administrative waste is a single-payer system. A single-payer system, I assume, would be the government, or more specifically the federal government. He further contends that the only reason not to take that last step (of creating a single-payer system) is to maintain "the ideological veneer of private enterprise."

I am left to conclude, therefore, that Dr. Brody's answer to reducing administrative waste and a burgeoning bureaucracy in our current health care system is to turn the whole thing over to the federal government, the same government that has created a $4 trillion deficit and increases it daily by $1 billion. If this is Dr. Brody's contention, then I will take "the ideological veneer of free enterprise" over federal peckerwood any day.

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The preceding letters were referred to the author of the article in question, who offers the following reply:

To the Editor: Dr. Gillette notes a number of obstacles to the implementation of substantial health care reform 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 drawbacks in its implementation phase. A single-payer system 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' concerns 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 numerous alternative models. Second, the facts about government waste and inefficiency might not square with our natural prejudices — for instance, why does the US Social Security System pay 5 percent for administrative overhead while the average private health insurance 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 contribution 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 summarized their data in helpful graphs. What was missing, however, was any elaboration of the subjective differences in these newsletters, which are large and important.

Questions that readers will have include the following: is the content directly relevant to office practice? Is the style readable and engaging? Is the point of 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 literature. The studies that are left out of these newsletters 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 specialists in other fields. I convey the personal dilemmas that 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 physicians, 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

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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.

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