sues, including the importance of an adequate call-group size, the optimal number of obstetric patients to care for at a given time, and how to secure appropriate specialty backup. At a higher level, it must be made clear to health care organizations who are courting the favor of family medicine and family practice residents that obstetrics is a part of the specialty and that past practices and other specialists' beliefs will not dictate the scope of family practice. Finally, as a practice alternative to these organizations, desire to do obstetrics could be used as an incentive to direct residents to practice in rural areas, where the need for obstetric providers is great and the barriers are minimal.

As the health care system goes through the dramatic changes that are likely to occur during the next couple of years, it is critical that family medicine clearly define itself not only in its philosophy toward health care but also in the scope of practice that it includes. The argument is still being made by some in academic family medicine that obstetrics be dropped as a requirement of residency education. If the scope of family practice does not include the basic elements of health care for families (in fact, normal pregnancy is one of the most common reasons that persons seek medical care in the outpatient setting in the United States), it severely weakens the argument that family physicians should serve as the cornerstone of health care in this country. If family medicine educators, practicing family physicians, and those in organized family practice are ambivalent about the role of obstetrics in family medicine and, therefore, fail to be committed fully to converting residents' intentions to practice obstetrics into practice realities, we risk tarnishing the image of the specialty in what very well could be its golden age.

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# Practice Guidelines For The Management Of Vague Patient Complaints?

Somatic symptoms that do not have a discrete organic cause account for almost one in every seven primary care outpatient encounters in the United States.[1] As clinicians, however, we often feel uncomfortable when caring for the patient with such undifferentiated symptoms as fatigue or headache. Given the traditional focus of medical education on specific disease states, most of us struggle with patients who have so-called "vague complaints" and would readily admit to greater skill in caring for patients whose disorders are better defined.

Next to fatigue, dizziness is the most common nonpain symptom reported in the ambulatory setting.[1] Dizziness is also one of the most com-

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plex symptoms for the clinician to evaluate, because it can represent a wide range of diagnoses that overlap our traditional specialty areas of otolaryngology, neurology, cardiology, endocrinology, and psychiatry. Moreover, the complaint of dizziness is unusually worrisome because it can be the first symptom of life-threatening cardiovascular or neurological conditions. Not surprisingly, clinicians evaluating dizziness in a patient often turn to some form of diagnostic testing intended to detect organic causes. One study of dizziness, however, reported that the search for an organic cause not apparent after the initial interview and physical examination had a diagnostic yield of only 9 percent and a cost of more than $2500 for each organic diagnosis discovered.[2] Moreover, dizziness has been shown to be often unresponsive to usual therapies[1] even though it can cause patients considerable discomfort.

Such apparent inefficiencies and uncertainties about the evaluation and management of a symptom complex reported frequently in the primary care setting seem to point to the need for a clinical practice guideline on dizziness. Would not both patients and physicians benefit from the development of guidelines that summarize scientific data about dizziness and recommend management strategies supported by this information?

The paper "Management of Dizziness in Primary Care" by Sloane and colleagues published in this issue of *JABFP*[3] offers information that supports a need for guidelines on dizziness but also raises questions about the feasibility of developing guidelines for such a vague patient complaint. The authors describe the management by primary care physicians of patients who were treated for dizziness and observed for a 6-month period. The distribution of diagnoses reported in this study among patients seen for dizziness in the primary care setting appears to differ from that noted previously among referral populations.[4] Moreover, the authors' data do not support the textbook assumption that clinicians must quickly distinguish between benign and threatening causes of dizziness. Months of follow-up might be required before the physician is able to get a diagnostic handle on the condition, and conservative management of patients during this extended period of assessment appears to be associated with a low mortality.

## Diagnostic Uncertainty and Variability in Patient Management

Physicians in this study were asked on the initial patient visit to make an estimate of the level of their diagnostic certainty and of their level of "worry" about life-threatening conditions. On average, the physicians were less than 75 percent certain about the diagnoses they made and were significantly less certain when there was reason to worry about such potentially serious conditions as arrhythmia, brain tumor, or transient ischemic attack. The researchers also detected considerable variation in the management approaches of physicians participating in their study. Although the finding is mostly anecdotal, given the small number of physicians involved, such practice variations are thought to result in part from the very uncertainty about proper evaluation and clinical management that this study has documented. At least some of the variations in our current medical practices are perceived to reflect excessive (or inadequate) care.[5] Guidelines have been offered as one method of reducing such unexplained variation in care.[6]

## Specific versus Nonspecific Conditions

As defined by the Agency for Health Care Policy and Research (AHCPR), however, practice guidelines have been promoted to "assist practitioner and patient decisions about appropriate health care *for specific clinical circumstances.*"[7] Clear definitions of target disorders are considered important to assure that guidelines are not applied inappropriately in the clinical setting. We know, however, that dizziness is often a patient's shorthand description of an enormous variety of symptoms, many of which have nothing to do with balance disorders. In evaluating dizziness in any patient, both the clinician and the researcher are first required to categorize the patient's subjective complaints.

Previous researchers have divided the symptom complex of dizziness into four categories: vertigo, presyncope, disequilibrium, and lightheadedness.[4] Sloane and colleagues have added a fifth category of "other," which includes 35 percent of the dizziness sensations reported by their study population. The appropriateness of such a miscellaneous category is supported by the authors' observation that the study patients (especially the elderly) often had great difficulty

communicating symptoms of dizziness to their physicians. This finding warns us that in addition to the danger of defining a vague condition too broadly for the purposes of guidelines, there is also the danger of a definition being too focused. In such a case, the guideline might well apply to the care of only a small proportion of the affected population and might also be directly supported by only a small body of scientific evidence.

### Patient Outcomes

An even more important barrier to the development of a guideline on dizziness is the lack of information to date on the clinical outcomes that are either desirable to patients with the condition or are to be avoided. Sloane and colleagues have confirmed the observation of others[8,9] that dizziness is rarely a life-threatening illness. As the authors point out, however, a low mortality rate does not exclude the presence of interval morbidity. We need to define other outcomes potentially important to patients — such as duration or number of episodes of dizziness and resultant mobility impairment or reduction of normal activities — as well as patient expectations of treatment received. Given the heterogeneity of the condition, however, we might well expect to find a wide spectrum of preferred outcomes for patients with dizziness.

Provided that measurable outcomes (either benefits or risks) can be ascertained and prioritized, the effect of each physician intervention on each outcome needs to be assessed under defined conditions to determine the appropriate (or inappropriate) uses of the intervention. Only then can the risk-benefit ratio of specific management strategies for vague patient complaints be assessed and observed variations in physician practices (such as those noted by Sloane and colleagues) be adequately evaluated as justified or unjustified. This information will first help us answer the question of whether practice guidelines for symptoms such as dizziness are necessary and are likely to improve patient outcomes. It will also be the evidence upon which specific recommendations for the management of vague, nonspecific complaints in the primary care setting need to be based.

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# Board News

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### Specialty Recertification in Modern Practice

The concept and practice of recertification in medical specialties were slowly and painfully developed in an era when competition among medical providers was largely based on individual qualifications. In those circumstances, patients and their families could rely on the certification process to assure that physicians had