Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints might 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.

Transdermal Nicotine Patches

To the Editor: In the September-October 1994 issue of *JABFP*, Montalto, et al. describe a possible suicide attempt by a 15-year-old girl who placed 14 transdermal nicotine patches on her body.[1] Your readers might be interested in a fictional murder attempt using the patches described in *Thank You For Smoking* by Christopher Buckley.[2] Nick Naylor, the chief spokesman for the Academy of Tobacco Studies, is kidnapped and covered completely with nicotine patches. He survives the resulting paroxysmal atrial tachycardia, nausea, vomiting, skin rash, blurred vision, neuralgia, and cold numb extremities. Nick concludes that smoking saved his life, and that the nicotine patches are killers. But he can no longer tolerate cigarettes — a major liability in his job. All ends well, however, with Nick working for Clean Lungs 2000, an organization that tries to get people to stop smoking. I highly recommend reading the book (after finishing the current issue of JABFP, of course)!

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References

1. Montalto N, Brackett CC, Sobol T. Use of transdermal nicotine systems in a possible suicide attempt. J Am Board Fam Pract 1994; 7:417-20.
2. Buckley C. Thank you for smoking. New York: Random House, 1994.

Open-ended Vasectomy

To the Editor: As Denniston and Kuehl[1] reported in their article, and affirming previous reports, the open-ended vasectomy technique has "low complication and failure rates." The open-ended technique implies that no occlusive procedure (cautery or ligation) is performed to the testicular end of the divided vas deferens.

Having performed approximately 200 vasectomies and reviewed the literature, I would suggest that what has been presented as the open-ended vasectomy is more accurately the semi–open-ended vasectomy, as only one of the two ends of the divided vas deferens is left open. The technique I use is a modification of the one described by Schmidt[2] but with no occlusion of either end of the vas. To the best of my knowledge there have been no failures, and no patient-initiated return visits for complications — hematomas, granulomas, or infections.

As much as Denniston and Kuehl and their predecessors have shown improved outcome by not occluding the testicular end of the vas, I am unaware of any substantive evidence supporting the occlusion of the prostatic end of the vas.

My experience suggests a comparable (positive) outcome from performing no occlusive procedure on either end of a divided vas deferens. That same experience and review of the literature strongly suggests that the keys to successful vasectomies (low or no failures or complications) are being familiar and comfortable with the technique, meticulous attention to basic fundamentals (i.e., hemostasis), and the interposition of a fascial sheath between the divided ends of the vas.

If the semi–open-ended vasectomy approaches the ideal vasectomy, a truly (both ends) open-ended technique might even more closely approach the ideal. Such practice-based research is well-suited to and, as demonstrated by Denniston and Kuehl, can be done well by family physicians.

Daniel J. David, MD
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References

1. Denniston GC, Kuehl L. Open-ended vasectomy: approaching the ideal technique. J Am Board Fam Pract 1994; 7:285-7.
2. Schmidt SS. Techniques and complications of elective vasectomy. Fertil Steril 1966; 17:467-82.

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

To the Editor: Dr. David's letter and comments concerning open-ended vasectomy are appreciated. The rationale for closing the prostatic end of the cut vas is to prevent failures. Cauterizing *and* covering it should increase the probability that failure will not occur. On the rare occasions when the interposed barrier fails, the cauterized vas prevents recanalization and thus unwanted pregnancy. Even if Dr. David's series went to 4000 cases with careful follow-up and with no failures, these results would only testify to his skill in consistently interposing a barrier. A truly open-ended technique should not be as effective as our method in preventing failures in other hands.

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Laurel Kuehl
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Communication in Consultation Process

To the Editor: Scott & White is a large multispecialty group of 429 physicians and 205 residents, including 66 family physicians at 11 regional clinic sites, associated with a 100,000-member health maintenance organization and a 400-bed hospital. Because of our own

experience with communication problems between subspecialists and family physicians, we recently conducted an internal survey with many similarities to the Williams and Peet survey described in a recent issue of *JABFP*.[1] Questionnaires were distributed to 200 subspecialists, and there was a response rate of 52 percent (104) from approximately 20 specialty areas.

Within the Department of Family Medicine, the physicians perceived that lack of feedback from consultants is a major problem, particularly feedback regarding diagnostic testing or procedures done after the initial visit with the consultant. Surprisingly, a large number of respondents (58 of the 104) accepted personal responsibility for this communication failure. We believe this response might indicate a need for educating not only referring physicians, but also consulting physicians regarding the importance of communication in the referral process.

Regarding secondary referrals (referral of a patient from one consultant to another without input from the primary physician), 25 consultants indicated they discuss the secondary referral with the referring physician less than 10 percent of the time, while only 15 consultants indicated they always discuss possible secondary referrals with referring family physicians. Family physicians view this as problematic, and we suggest this response also indicates a need to educate consultants.

Regarding method of communication preferred, 70 respondents indicated that a photocopy of the chart of a recent office visit was what they needed, 55 indicated that they needed pertinent laboratory and radiographic reports, 28 indicated a consultation slip was sufficient, and only 13 indicated a telephone call was necessary. While these findings are in contrast to those of the Williams and Peet survey, we think they might be indicative of the nature of our own particular organization.

As for our response, the Referral and Relations Committee of the Department of Family Medicine reached the conclusion that conscious attempts to improve the communication in the consultation process through both individual and group efforts might represent our most effective approach in problem solving. Each committee member was charged with going back to his small group of physicians and presenting an idea for a common approach to our consultants when our information needs are not met. We have also made administrative changes. In addition, the Referral and Relations Committee has taken on the task of meeting in small groups with subspecialties to discuss our mutual communication needs. While the process is ongoing, an overall impression exists that the situation is steadily improving.

While not necessarily generalizable to other organizations, this bit of information can offer an interesting reflection from an integrated system.

According to Weiner,[2] within the next 6 years we can expect that the supply of specialists will outstrip the requirements of the United States by more than 60 percent. Perhaps the time is right for family physicians to define their communication needs to specialists more clearly.

Jim Madsen, MD
Barbalee Symm, RN, MS
Scott & White
Temple, TX

References

1. Williams PT, Peet G. Differences in the value of clinical information: referring physicians versus consulting specialists. J Am Board Fam Pract 1994; 7:292-302.
2. Weiner P. Forecasting the effects of health reform on US physician workforce requirement. Evidence from HMO staffing patterns. JAMA 1994; 272:222-30.