Caring for Deaf Patients

To the Editor: I am writing this letter to comment upon one aspect of the article by Ralston and colleagues in the May-June issue (Ralston E, Zazove P, Gorenflo DW. Physicians attitudes and beliefs about deaf patients. J Am Board Fam Pract 1996;9:167-73). In the article she makes the otherwise unsupported statement that the "Americans with Disabilities Act (ADA) requires that doctors provide deaf and hard-of-hearing patients with interpreters in doctors' offices at the doctors' expense." I am not a lawyer, and I do not pretend to know the details of the ADA. Not too long ago, however, I did discuss the ADA with some experts at the American Academy of Family Physicians. There was a considerable difference of opinion as to whether a small family practice office, especially in a rural area, would be required to provide an interpreter at the physician's expense for all deaf patients' visits.

The difficulty, I believe, is in deciding what constitutes a reasonable accommodation. Is it reasonable to provide an interpreter for an office visit when the cost of the interpreter will far exceed the charge for the office visit? In large offices located in metropolitan areas, it is possible to have interpreters available so that the cost is spread out among multiple patient visits, and thus it might be reasonable to provide that accommodation. This might not be so, however, when there are fewer deaf patients involved, and the interpreters must come from a much greater distance at a much greater expense. Unfortunately, as is too often the case with these well-intentioned but misguided efforts at social engineering, the answer to this question will probably be determined by the courts.

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NIH Consensus on *Helicobacter pylori* in Peptic Ulcer Disease

To the Editor: I share a lot of the concerns that Dr. Berg has pointed out in his comments on the NIH consensus statement on *Helicobacter pylori* in peptic ulcer disease.[1] My main problem with the consensus, however, is that it is mostly geared toward subspecialists rather than family physicians. As an academic and practicing family physician, I attempt to keep up with practice guidelines that have an impact on the care of my patients. I believe that the recommendation of the consensus to perform an upper gastrointestinal endoscopy with biopsies on every patient with suspected peptic ulcer disease is impractical and not cost-effective.

The NIH consensus specifically states that 95 percent of patients with duodenal ulcer disease are infected with *H pylori*.[2] Then why should we not empirically treat with antibiotics all patients with duodenal ulcers diagnosed radiographically? Studies have shown that biopsy results and testing for *H pylori* are very expensive and that empirical treatment is far more cost-effective in patients with high pretest probability for *H pylori* infection.[3] Similarly, a cost analysis study by Imperiale et al[4] has proved that initial empiric treatment of duodenal ulcers with antibiotics and H_2 blockers is the most cost-effective treatment when the prevalence of *H pylori* infection exceeded 66 to 76 percent.

Approaches of family physicians to this disease entity might be different. Family practice clinical encounters research has shown that the problem manifests itself to us as dyspepsia rather than an ulcer.[5] Sensitivity and specificity of noninvasive *H pylori* testing have been improving. Breath tests, which detect ureases produced by the organism, have shown 90 percent sensitivity and 95 percent specificity.[6] A positive breath test, coupled with typical symptoms, could be a factor to consider in treating patients with H_2 blockers and antibiotics as well. This therapeutic regimen might prove to be more practical to primary care physicians compared with upper gastrointestinal endoscopy and biopsies.[7]

Finally, the medical literature has shown that involving family physicians in the process of formulating guidelines results in more acceptance and compliance with the guidelines which pertain to their daily practice.[8] Now that the gastroenterologists have produced their own guidelines,[9] I believe the best approach for us is to refine the existing specialty guidelines and consensus in a way that suits primary care practice. This effort could be accomplished with the help of societies such the American Board of Family Practice or the American Academy of Family Physicians.

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