Letters to the Editor

To the Editor.—I continue to greatly enjoy *The Permanente Journal*. May I suggest that you change Dr. Garfield's name from Kaiser Physician to Permanente Physician. As far as I know, there are only a small handful of physicians who work for Kaiser (I happen to be one who works for Health Plan half-time). The vast majority of us work for the various Permanente Medical Groups, not Kaiser. Since Dr. Garfield founded The Permanente Medical Group, I doubt that he would consider himself to be a Kaiser physician.

Bruce Locke, MD
Surgeon
The Permanente Medical Group

In Reply.—Truthfully, I had already heard from several people here in North Carolina from the very beginning that "Kaiser Physician" is a distinct no-no. I kind of left it at that because I got a kick out of everyone correcting me. Certainly, it has to be agreed that everybody calls us "those Kaiser doctors," and behind closed doors, that is what we even call ourselves. But, alas, it is not politically correct and must be remedied (in a future issue). I think we can change it and that will make things right. Perhaps it will even make good fodder for a future cartoon. Please note, however, that Stan Garfield is not related to Sidney, and if anyone asks, no connection was intended. The fact that the names are similar may well be mere coincidence.

Joseph Oleniacz, MD
Pediatrician and creator of the comic strip
"Dr. Garfield, Kaiser Physician" (See page 78)
The Carolina Permanente Medical Group

To the Editor.—I have just finished Vol 1, No. 2 of *The Permanente Journal*. Although I was not impressed with the first issue and considered it to be just another unnecessary expense to the medical groups, I am impressed with the second issue and have saved a number of articles, specifically "Managed Care Risk Management" (p. 68-70, by Roger Miyaji, JD), "A New Moment in the History of Kaiser Permanente" (p. 46-50, by Francis J. Crosson, MD), "Primary Care Redesign" (p. 33-36, by Rob Ryan, MD), and "Selecting and Interpreting Diagnostic Tests" (p. 4-7, by Barbara Scherokman, MD). I have kept the middle two articles because I want to remember the member/authors of these projects. The other articles I have kept because of useful information I hope to apply to my practice.

I particularly enjoy the artwork, poems, and cartoons that are a part of this *Journal*; in fact, I would like to know if Wu-Hao (Taki) Tu, MD has a book/collection of his watercolors in print or available in some manner.

I enjoy having the pictures of authors included with the text, as it personalizes their articles. I would advise, though, that it would be of benefit if the Abstracts truly were abstracts and followed that format. I'm looking forward to the next issue.

Thomas Butler, PA
Orthopedics
The Carolina Permanente Medical Group

In Reply.—Dr. Tu is currently putting together a collection of his work to be published. He also has paintings on display at the William Lester Gallery in Point Reyes Station, CA (415-663-9365). If you would like more information about Dr. Tu's work, or about the art of painting and how to get started, you can e-mail him at whtu@dnai.com or fax 925-254-2976.

Merry Parker
Managing Editor

To the Editor.—I just read the enthusiastic letters in the recent issue (Winter 1998) of *The Permanente Journal*. I found it interesting that none were from exclusively clinical providers. I am not sure I share their appreciation for the content of the *Journal* and its relevance to patient care.

In these days of multimillion-dollar losses, I feel that Kaiser has to reconsider expenditures on this type of project, that seem mostly to reinforce our own positive image of ourselves without significantly adding to problem-solving strategies or patient care.

David Kaufman, MD
Family Practice
Northeast Permanente Medical Group

In Reply.—Thank you for your thoughtful comments. These letters you read from Health Plan managers across the Program were an attempt to recognize that *The Permanente Journal* also has value for our partners in Kaiser Permanente. The recent letters have been overwhelmingly congratulatory, so we published what we received. In the letters in this issue, you will see that some people are speaking out in different ways, like yourself.

We appreciate all comments and will publish them, as we seek to have a dialogue about anything that clinicians and their partners see as important to our ultimate goal of serving our members better.

How the Program spends our members' money is always critically important, and all must evaluate that every time we make a decision requiring an expen-

diture of resources. I am trying to add value with every issue we publish, and the measure of that is your perception of the utility of the information in helping you care for our patients better. Please continue to let *The Permanente Journal* team know if we are meeting your needs.

Tom Janisse, MD
Editor-in-Chief

To the Editor.—Sachs and Smith[1] describe the successful accomplishment of ambulatory shoulder surgery, which is difficult because the surgery is usually painful. They correctly recognize that high doses of narcotics to treat the pain cause side effects (including nausea and urinary retention) that delay discharge.

I believe the key to their success is the use of local anesthetic in the wound so that narcotics for pain control are minimized. They also lessen the need for narcotics by using ketorolac, one of many nonsteroidal anti-inflammatory drugs with morphine-sparing properties but the only one available in injectable form.

They misunderstand the kinetics of the induction drugs, thiopental and propofol, and attribute too much credit to induction with propofol. Both propofol and thiopental are redistributed within minutes from blood to other tissues. As a result, the wake-up after an induction dose of either drug is equally quick.[2] Both are metabolized by hepatic conjugation with renal elimination, so the terminal half-life of both drugs is many hours.

1. RA Sachs, JH Smith. Ambulatory Open Shoulder Surgery. *The Permanente Journal* 1998;1(2):6-9.
2. RT Blouin, PF Conrad, JB Gross. Time course of ventilatory depression following induction doses of propofol and thiopental. *Anesthesiology* 1991;75;940-4.

Kenneth D. Larsen, MD
Anesthesiologist
Northwest Permanente

In Reply.—We believe that the choice of propofol for ambulatory surgery is based on sound pharmacokinetic and pharmacodynamic research. Dr. Larsen is correct that the redistribution phase for propofol and thiopental are roughly equivalent. That is, plasma levels of both drugs decline rapidly as each drug is redistributed from highly perfused tissues, such as the brain, into less well-perfused-tissues, such as muscle and fat. Thus, as Dr. Larsen pointed out, "the wake up from either drug is equally quick."

Subsequently, however, the metabolic clearance of propofol occurs approximately ten times faster than that of thiopental. This explains the common observation that thiopental patients wake up feeling hung over, whereas propofol patients exhibit clearer sensorium and more rapid psychomotor recovery.

In the ambulatory setting, particularly when many cases are being done in the late afternoon, the rapid metabolic clearance of propofol allows a measure of assurance that the patient will be able to be discharged, and makes it the anesthesia drug of choice.

Raymond Sachs, MD, and Joanne Zupan, MD
Orthopedics and Anesthesiology, respectively
Southern California Permanente Medical Group

To the Editor.—I read with interest the panel discussion on systems challenges ("Systems Challenge for Primary Care and the Specialties: Relationship and Access. A Roundtable Discussion." p. 42-47) in the latest issue (Winter 1998) of *The Permanente Journal.* The term "referral guideline" surfaced again. I have found this term to be misleading. We should be talking about what the proper diagnostic work-up and treatment for each pathology is, not about when to refer. The referral is a natural product of following a practice guideline.

When the practice guideline outstrips the primary care physician's capability (or, for that matter, capacity), physicians must refer so that the guideline can continue to be followed. That referral may be internal or external—or in sequence. Different pathologies will have different referral points, and these may vary from Region to Region, from clinic to clinic, or even from doctor to doctor.

We should be spending our efforts in developing consensus practice guidelines, not on when a pathology should be referred—that will follow naturally.

Karl Pregitzer, MD
Emergency Medicine
Hawaii Permanente Medical Group

In Reply.—Dr. Pregitzer is correct in his encouragement that we focus our deliberations on practice guidelines rather than on guidelines as to when to refer to specialists—only one aspect of the care continuum.

The panel for this Systems Challenge raised the issue of referral guidelines as it addressed the primary care physician and specialist interaction, a source of tension for the Permanente Groups. It was dialogue around this question that led the panel to consider the impact of referral guidelines. Dr. Pregitzer is correct; our clinical focus should be on the overall care of the patient rather than on this one aspect.

The Permanente Journal has received other feedback on this Systems Challenge. Although the panel

discussions gave very low ratings to direct specialist-primary care physician feedback following referral, apparently some redesign models still incorporate this strategy, as many believe it is in fact worthwhile. Time will tell what the effectiveness will be as you roll out your primary care design. Let *The Permanente Journal* readers know what you learn.

Appropriate referrals and enhancing the relationship between primary care physicians and specialists will continue to be a major challenge for Permanente Groups, and for that reason dialogues such as that in our Systems Challenge will be extremely valuable.

In my opinion, and in the opinion of several of the panelists, the "real time" sharing of information between the referring provider and the consultant by use of the telephone (eg, the Urophone in the Northwest) was probably the most valuable learning during the roundtable discussions. Especially noteworthy was the reported high satisfaction that the primary care providers have with the process.

Lee Jacobs, MD
Associate Editor, Health Systems Management

To the Editor.—I thoroughly enjoyed the article, "Cultural Competence in Health Care: Another Aspect of Kaiser Permanente's Commitment to Quality," published in Vol 2, No. 1 of *The Permanente Journal.*

I want to congratulate Jean Gilbert on her effort in bringing awareness to Kaiser Permanente physicians across the country about this very important aspect of our medical practice. I wholeheartedly agree with Dr. Gilbert that delivering culturally competent care is simply delivering *quality care*—to which our organization has always been committed—and is *not* stereotyping, nor is it giving special treatment to special groups.

In our San Francisco facility, we have now established Adult Primary Care Chinese and Hispanic modules. We believe that by interpreting different groups' health-related beliefs and cultural values, we physicians are giving better care. We just need to continue to spread the word.

Towie Fong, MD
Chief of the Bilingual Chinese Module
The Permanente Medical Group

To the Editor.—Swenson and Acton's article, "Building and Delivering the Kaiser Permanente Promise" (2(1):33-36), seems to me to be trying to fit a service model of brand identity to a product model of business. Differences in marketing and delivery flow from this obvious distinction.

The basic problem of branding, or of any marketing of a service, is how you can differentiate your service from someone else's and how the loss of customers, or their perceived dissatisfaction, may be related to a loss of Kaiser's distinction.

People stay in Kaiser because they view the entire organization as one dedicated to their care. The providers only treat Kaiser patients, the hospital only treats Kaiser patients, and the clinics only see Kaiser patients. A loss of any one of these elements places Kaiser in the pack with the rest of the country's HMOs.

And if you're like all the other HMO's, why should anyone view your offered services as unique?

Stephen C. Acosta, MD
Emergency Medicine
Northwest Permanente

Extending Life

"If you only had a week to live, where would you go?
Detroit—because it would seem like a year."
Source unknown