

to 2 weeks). Perhaps this success is due to the sedative properties causing improved sleep and therefore improved outlook, perhaps it is because I am treating sub-clinical depression, or perhaps it is all placebo effect.

I have the utmost respect for the research community and believe it is important for us to objectively evaluate treatments. However, as one of the "guys in the trenches," I am stuck treating patients. If I can give a trial of a nonaddictive, fairly well-tolerated, inexpensive (generic amitriptyline costs about \$5 to \$10 a month) treatment modality that may improve my patient's outlook, it would seem cruel not to do so, particularly when the alternative is not to treat at all. When it comes to helping patients, I'll take placebo effect if I can get it, at least until we can find a more viable alternative.

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The preceding letters were referred to Dr Turner, who chose not to respond.

PRENATAL SMOKING CESSATION

To the Editor:

I would like to congratulate you on the articles in the March issue of *The Journal of Family Practice* relating to children and passive smoking,¹ and smoking and preterm birth and low birthweight.²

As a medical director for an HMO, I know that managed care has a great opportunity to have an impact on this problem because the patient does not have any added costs if she accesses obstetrical care early and smoking cessation programs are offered as part of her benefits.

At Maxicare, we have developed a serialized self-help smoking cessation program for pregnant women.³ We try to identify all smokers at the beginning of their pregnancies.

Pregnant patients are reported by the Independent Physicians' Association and medical groups to Maxicare when they first consult for prenatal care. The women are sent a variety of informational items at each trimester. For those who state that they are smokers, we send eight weekly issues of a smoking cessation booklet. These are attractive, helpful, and easy to understand. A population-based randomized clinical trial that tested the effectiveness of the program was undertaken. The results showed that 22.2% of the women in the 8-week series quit as compared with 8.6% of the controls. Maxicare would be happy to share this program with any interested parties.

The increased risks of maternal smoking include low birthweight, prematurity, spontaneous abortion, perinatal mortality, sudden infant death syndrome, and long-term neurotoxicity affecting neurobehavioral development.^{2,4} We know that our efforts will not only result in better health for our children but also have a significant effect on immediate and future costs.

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ASTHMA MANAGEMENT

To the Editor:

I am in full agreement with Barach¹ that outpatient management of acute exacerbations of asthma should include objective measurements of airway obstruction. As Barach states, hand-held peak expiratory flow rate (PEFR) meters are

readily available, inexpensive, and easy to use, and they contribute important quantitative information to the decision whether to hospitalize. In my opinion, every site that manages acute asthma should measure PEFR during acute exacerbations of asthma. Regarding chronic asthma, I would like to share some of my perspectives on spirometry, education, and rising prevalence, which may differ somewhat from those of Barach.

My experience after performing a large number of tests is that patient compliance is a minor problem in obtaining reproducible spirometry (ATS criteria) in older children and adults. Serial measurements of FVC, FEV₁, and midflow rates (PEF 25%-75%) are more sensitive indicators of pulmonary function than PEFR, and are valuable for primary care clinical research on obstructive airway disease.² My experience has been that serial spirometry is also feasible in the clinical management of individual patients. In a survey of 240 family physicians belonging to the Wisconsin Research Network (WRnN), 119 (49.5%) reported the presence of a spirometer in the practice and presumably use spirometry at least to some extent. I agree that excessive charges for spirometry may be a limiting factor.

Barach makes the point that family physicians are in a unique position to provide ongoing education to patients with asthma. That home peak flow monitoring will improve asthma outcomes is an attractive but unproven hypothesis, and there is evidence that a simple diary is just as effective in identifying exacerbations.³ "Brief" (3 hours) education to improve inhaler skills and adjust drug dosages according to a treatment plan can decrease hospital admissions and emergency department visits.⁴ My beliefs are that primary care asthma education teams, adequate compensation for them, and research on their effectiveness will be necessary before the promise of decreased asthma morbidity will be realized in this country. It is sad that almost all published primary care asthma outcomes research has been performed outside the United States.

Like Barach, I believe that better clinical management can decrease asthma morbidity, although I am uncertain whether better clinical management will affect mortality as much as morbidity, because mortality may be significantly influenced by sociocultural factors beyond the reach of our clinical skills. Unlike Barach, I do not believe that asthma prevalence can be influenced by currently recom-

mended therapies, which are simply palliative and cannot be expected to affect possible underlying causes of asthma.⁵

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Comprehensive AIDS Workplace Program Responds to Urgent Business Needs

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Associate Director for HIV/AIDS
Centers for Disease Control and Prevention

Responding to estimates that one million Americans—or one in every 250 people—are infected with HIV (the virus that causes AIDS), a public-private partnership has created the nation's most comprehensive HIV and AIDS workplace education and assistance program—the Centers for Disease Control and Prevention's (CDC) "Business Responds to AIDS" (BRTA) initiative.

"Business Responds to AIDS" was designed to reach Americans at their workplaces because one-half of the nation's workers are between the ages of 25 and 44, and AIDS is currently the third leading cause of death in this age group. Leaders in the federal government are taking these statistics seriously. On September 30, 1993, President Clinton issued a directive to all federal agencies mandating HIV/AIDS education for all federal employees by December 1, 1994.

Already, two of every three large companies and nearly one in ten small businesses have faced AIDS among their employees. BRTA provides the necessary information and materials to create and implement job-site policies and programs.

Developed through the cooperative efforts of business, labor, government, health, and service organizations, BRTA offers an easily accessible, centralized source to assist all organizations—whether large or small, for profit or nonprofit, public or private, service or manufacturing—in meeting the increasing challenges of HIV infection and AIDS on the job and in the community at large.

Referrals, Materials Available by Phone
BRTA provides a toll-free Resource Service (1-800-458-5231) staffed by highly trained reference specialists who can provide information, materials, and referrals for developing HIV/AIDS workplace programs.

The Resource Service targets businesses of all sizes, organized labor, human resource professionals, and others seeking information about HIV and AIDS education programs.

Manager's Kits and Labor Leader's Kits Provide Step-by-Step Guidance

BRTA has developed a Manager's Kit and a Labor Leader's Kit to guide business and union leaders through the process of planning, developing, and implementing a comprehensive workplace HIV and AIDS education program.

The kits, consisting of brochures, resource guides, publication catalogs, and sample posters, outline how to develop a workplace policy as well as training and education programs for supervisors/stewards, employees, and employees' families.

The kits also encourage corporate involvement and volunteerism in AIDS prevention activities in the community. They are available at a nominal cost by calling the toll-free "Business Responds to AIDS" Resource Service.

Growing Partnership Backing the Program

Representatives from business, labor, and health groups have worked closely with CDC in the development of BRTA, with more companies and organizations joining the partnership every day. Key partners include the National Leadership Coalition on AIDS; the American Red Cross; the George Meany Center for Labor Studies of the AFL-CIO; the American Federation of State, County, and Municipal Employees; the Service Employees International Union; and numerous other federal, state, and local agencies.

Business and labor leaders can access this comprehensive assistance network by calling or writing:

Business Responds to AIDS

Resource Service

P.O. Box 6003
Rockville, MD 20849-6003
Phone: 1-800-458-5231
Facsimile: (301) 738-6616

