Number 4, 1990

Clearinghouse on Health Indexes

From the CENTERS FOR DISEASE CONTROL AND PREVENTION/National Center for Health Statistics

Bibliography on Health Indexes

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention
National Center for Health Statistics

ACKNOWLEDGMENTS

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This issue contains annotated citations of literature on composite measures of health status and quality of life, both published and unpublished, that became available in July, August, or September 1988. Materials searched in the preparation of this issue are given in the section entitled "Sources of Information," which follows the annotation section. Bibliographic citations are given in the standard form: author, title, and source of the article, designated by Au:, Ti:, and So:, respectively. As many as five authors are listed; the sixth and additional authors are identified by et al. Abbreviations are avoided whenever possible.

Following the abstract, the number of references used in the preparation of the document and source of the annotation are given. There are four sources: (1) the author abstract designated by AA; (2) the author summary, AS; (3) the author abstract or summary modified by Clearinghouse personnel, AA-M or AS-M; and (4) the Clearinghouse abstract CH-P, where the initial following the "-" indicates the individual responsible for the abstract.

Copies of items cited in the Clearinghouse bibliographies should be requested directly from the authors. The address for reprints is given after the abstract. When the request is to be sent to an author other than the first listed, the appropriate name is given along with the address.

REFERENCE NUMBER 1
Au: Addington-Hall, J.M.; MacDonald, L.D.; Anderson, H.R.
Ti: **Can the Spitzer Quality of Life Index Help to Reduce Prognostic Uncertainty in Terminal Care?**
So: *British Journal of Cancer* 62:695–699, 1990

Data from an on-going trial of co-ordinating care for terminally ill cancer patients are used to investigate whether the Spitzer Quality of Life (QL) Index can be used to reduce prognostic uncertainty in terminal care. Four questions are addressed. First, can doctors and nurses distinguish between patients with a prognosis of more or less than 1 year? Second, do the medical and nursing staff differ in their ability to estimate prognosis? Third, are there differences in the length of life remaining between groups of patients with different QL Index scores? Fourth, how well does the QL Index predict the likelihood of individual patients dying within 6 months of assessment? Doctors and nurses assigned between 17 and 25% of patients to the wrong prognostic group and were as likely to over-estimate as to under-estimate life expectancy. Medical and nursing staff did not differ in their ability to make prognostic judgments. Patients with a low QL Index score were more likely to die within 6 months than those with higher scores, but scores on the Index were not strong predictors of 6-month survival in individual patients. The Index is not accurate enough to be used to predict what sort of treatment terminally ill patients will require in the future and for how long. Nevertheless, it may prove valuable for those planning services for terminally ill cancer patients who require information on the levels of need in a population. (20 references) AA

Address for reprint requests: Department of Public Health Sciences, St. George's Hospital Medical School, Cranmer Terrace, London SW17 ORE, England.

REFERENCE NUMBER 2
Au: Bindman, Andrew B.; Keane, Dennis; Lurie, Nicole
Ti: **Measuring Health Changes Among Severely Ill Patients: The Floor Phenomenon**
So: *Medical Care* 28(12):1142–1152, 1990

The interest in measuring health status with survey instruments has not been matched with an analysis of their performance characteristics in the field. We used the Medical Outcome Study Short Form (MOS–20) to assess health outcomes among patients who were hospitalized in one of two public hospitals. We mailed the MOS–20 and a series of transition questions, which asked about changes in health, to patients admitted in the previous year. We received 414 completed surveys from 480 patients at baseline and follow-up data on 90% of these patients 6 months later. Baseline MOS–20 scores for study patients were significantly lower, corresponding to worse health, than previously reported outpatient and general population cohorts. While the direction of change on serial applications of the MOS–20 paralleled the patients' perceptions of change reported on transition questions, many patients who reported their health had become worse also recorded the lowest possible score on the MOS–20 at baseline. These low baseline MOS–20 scores prohibited the recognition of larger declines in function during the follow-up period. This floor in the response range creates an instrument bias against documenting a decline in health among severely ill patients, the group in which it may be most important to detect such a change. (18 references) AA

Address for reprint requests: Department of Medicine, Room 5H3, 1001 Potrero Avenue, San Francisco, California 94110

REFERENCE NUMBER 3

Au: Bowling, Ann
Ti: **Associations with Life Satisfaction Among Very Elderly People Living in a Deprived Part of Inner London**
So: *Social Science and Medicine* 31(9):1003–1011, 1990

In the present study 662 people, aged 85 and over, living at home in a socially deprived part of the east end of London were interviewed in order to ascertain their life circumstances, emotional well-being, mental and physical health status. The aim of the analyses presented here was to determine the impact of social networks and support, functional status, and reported morbidity on life satisfaction. Multiple regression analysis showed that physical health status was a stronger predictor of emotional well-being in relation to life satisfaction than social network characteristics. The uniqueness of the study lies in its concentration on a very elderly age group, predominantly in the lower socio-economic classes. (64 references) AA

Address for reprint requests: Hackney Health Authority, St. Leonard's Hospital, Kingsland Road, London N1 5LZ, England

REFERENCE NUMBER 4

Au: Carr, David; Jackson, Thomas; Alquire, Patrick
Ti: **Characteristics of an Elderly Driving Population Referred to a Geriatric Assessment Center**
So: *Journal of the American Geriatrics Society* 38(10):1145–1150, 1990

A retrospective, case-control study was performed to determine the characteristics of elderly drivers referred to an outpatient geriatric assessment center. It was hypothesized that the driving population was operating at a higher cognitive and functional level than nondrivers. One hundred eighty-two subjects meeting the entry criteria were studied. Twenty-three percent of the subjects were driving at the time of their assessment. Compared to nondrivers, drivers were younger ($P=.0001$), were more likely to be male ($P=.003$), and were more independent in Physical and Instrumental Activities of Daily Living ($P<.0001$). Despite these findings, the mean Folstein Mini-Mental score for drivers (23.7) was below normal; 40% of drivers were diagnosed as having Alzheimer's dementia at the time of their evaluation, and over 26% of the drivers needed help with either dressing or bathing. The frequency of impaired elderly drivers in this referral setting was high. The authors conclude that conditions that affect the driving task are common in geriatric assessment centers. Prospective studies of elderly drivers are needed to answer the difficult question of who among the elderly should drive. (11 references) AA

Address for reprint requests: St. John's Mercy Hospital, 621 S. New Ballas Road, St. Louis, Missouri 63141

REFERENCE NUMBER 5

Au: Cheng, T.A.; Wu, J.T.; Chong, M.Y.; Williams, P.
Ti: **Internal Consistency and Factor Structure of the Chinese Health Questionnaire**
So: *Acta Psychiatrica Scandinavica* 82:304–308, 1990

The internal consistency and factor structure of the Chinese Health Questionnaire (CHQ) were investigated in 2 samples in Taiwan, one from 3 communities (n = 1023) and the other from consecutive attenders for health screening in a general hospital (n = 86). Cronbach's alpha coefficients were calculated to be 0.84 and 0.83 for the 12-item and 0.90 and 0.92 for the 30-item CHQ version. Four factors similarly extracted for the CHQ-30 in both samples include somatic symptoms, anxiety and worrying, social dysfunction, and depression and poor family relationship. The implications of these findings were discussed from a cross-cultural perspective. (21 references) AA

Address for reprint requests: Department of Psychiatry, National Taiwan University No.1, Chang-TE Street, Taipei, Taiwan, Republic of China

REFERENCE NUMBER 6

Au: Dailey, Patrick A.; Bishop, George D.; Russell, I. Jon; Fletcher, Ellen M.
Ti: **Psychological Stress and the Fibrositis/Fibromyalgia Syndrome**
So: *Journal of Rheumatology* 17(10):1380–1385, 1990

The relationship of stress and social support to the fibrositis/fibromyalgia syndrome (FS) was investigated by administration of 4 questionnaire instruments to 28 patients with FS, 20 patients with rheumatoid arthritis (RA), and 28 pain-free normal controls. FS showed higher levels of stress as measured by daily "hassles" than did RA or controls. However, on a measure of major life stress, they reported lower levels. No differences were found between groups with regard to daily "uplifts" or social support. Correlations between those measures of stress and social support with their scores on the Arthritis Impact Measurement Scale showed that the Hassles Scale was significantly related to the AIMS Psychological component. (30 references) AA

Address for reprint requests: Division of Behavioral and Cultural Sciences, University of Texas at San Antonio, San Antonio, Texas 78285

REFERENCE NUMBER 7

Au: de Haes, J.C.J.M.; van Knippenberg, F.C.E.; Neijt, J.P.
Ti: **Measuring Psychological and Physical Distress in Cancer Patients: Structure and Application of the Rotterdam Symptom Checklist**
So: *British Journal of Cancer* 62(6):1034–1038, 1990

Use of the Rotterdam Symptom Checklist (RSCL) to measure psychological and physical distress as experienced by cancer patients is discussed in this paper. The stability of the structure of the RSCL was assessed in principal component analyses in three studies: one concerning cancer patients during either chemotherapy or follow-up (n = 86), one done in patients undergoing chemotherapy for advanced ovarian cancer (n = 56), and the third dealing with cancer patients under treatment, disease-free 'patients,' and 'normal' controls (= 611). The psychological dimension proved to be stable across populations. A scale based on this factor was highly reliable (Cronbach's alpha 0.88–0.94). The physical distress is reflected by several dimensions in a homogeneous population (pain, fatigue, gastrointestinal complaints) and unidimensionally in a heterogeneous population. Reliability of the physical distress scales is good (0.71–0.88). The current components of the RSCL and the use of individual and disease-specific symptoms are discussed. (24 references) AA

Address for reprint requests: Department of Medical Psychology, University Hosptial (AMC) Meibergdreef, 1105 AZ Amsterdam, The Netherlands

REFERENCE NUMBER 8

Au: Ebell, Mark H.; Smith, Mindy A.; Seifert, K. George; Polsinelli, Kenneth
Ti: **The Do-Not-Resuscitate Order: Outpatient Experience and Decision-Making Preferences**
So: *Journal of Family Practice* 31(6):630–636, 1990

Do not resuscitate (DNR) orders have become a widespread part of modern medical practice. This study examined patient experience and decision-making preferences regarding cardiopulmonary resuscitation. A random sample of 800 outpatients (one half aged over 70 years) was surveyed by questionnaire, with a 51% response rate. While only 11% of patients had ever discussed resuscitation with a physician, 67% had thought about the issue, and 44% had discussed it with someone other than a physician. Patients overwhelmingly preferred to preserve a good quality of life, even if it meant not living longer (93.9%). When asked who they would have help them with DNR decision, physicians were most often selected, while spouses were the most valued advisors. In a series of scenarios such factors as dementia, drug or alcohol use, age, and pain had a significant effect on a patient's decision about resuscitation. Discussions about DNR issues in the outpatient setting should be encouraged, as patient interest is strong, and greater physician awareness of patients' values and preferences can prevent unwanted resuscitation in the acute setting. (17 references) AA

Address for reprint requests: Rt 2, Box 91A, Colbert, Georgia 30628

REFERENCE NUMBER 9

Au: Essink-Bot, Marie-Louise; Bonsel, Gouke J.; Van der Maas, PaulJ.
Ti: **Valuation of Health States by the General Public: Feasibility of a Standardized Measurement Procedure**
So: *Social Science and Medicine* 31(11):1201–1206, 1990

In the context of an international collaborative study we tested the feasibility of a utility measurement procedure in the Dutch general population. A postal questionnaire was sent to a random sample of 200 households in a town in the Netherlands (50,000 inh.). Respondents were requested to value 14 six-dimensional health states by means of visual analogue scaling (VAS). The response was satisfactory (57%), though about a fifth of those willing to complete the questionnaire did not manage to use a VAS to express their opinion. Inconsistent answers occurred relatively seldom. Generally consensus existed with regard to relative (ranking) and absolute values of different health states. These first results encourage us to go on with the development of this international instrument for the valuation of health states. We conclude the present instrument to be a feasible tool for valuation research, although questions relating to its measuring properties, as well as its reliability and validity remain to be answered. (27 references) AA

Address for reprint requests: Erasmus University Rotterdam, Post Office Box 1738, 3000 DR Rotterdam, The Netherlands

REFERENCE NUMBER 10

Au: EuroQol Group
Ti: **EuroQol—A New Facility for the Measurement of Health-Related Quality of Life**
So: *Health Policy* 16(3):199–208, 1990

In the course of developing a standardized, non-specific instrument for describing and valuing health states (based on the items in Table 1), the EuroQol Group (whose members are listed in the Appendix) conducted postal surveys in England, the Netherlands, and Sweden which indicate a striking similarity in the relative valuations attached to 14 different health states (see Table 3). The data were collected using a visual analogue scale similar to a thermometer (see Table 2). The EuroQol instrument is intended to complement other quality-of-life measures and to facilitate the collection of a common data set for reference purposes. Others interested in participating in the extension of this work are invited to contact the EuroQol Group. (12 references) AA

Address for reprint requests: Centre for Health Economics, University of York, York Y01 5DD, United Kingdom

REFERENCE NUMBER 11

Au: Evans, Robert G.; Stoddart, Gregory L.
Ti: **Producing Health, Consuming Health Care**
So: *Social Science and Medicine* 31(12):1347–1363, 1990

In this paper, the authors propose a framework that is sufficiently comprehensive and flexible to represent a wide range of relationships among the determinants of health. This aims to be an analytic framework for incorporating the main determinants when such research evidence is available. Only cursory indications for health policy are suggested, the role of the framework being to facilitate the presentation of evidence. (60 references) CH-P

Address for reprint requests: Department of Economics, University of British Columbia, Vancouver, BC, Canada V6T 1W5

REFERENCE NUMBER 12

Au: Finn, Stephen E.; Bailey, J. Michael; Schultz, Robert T.; Faber, Raymond
Ti: **Subjective Utility Ratings of Neuroleptics in Treating Schizophrenia**
So: *Psychological Medicine* 20(4):843–848, 1990

This study developed a method for measuring subjective costs and benefits of psychiatric treatments. Forty-one patients rated the relative bothersomeness of symptoms of schizophrenia and side effects of neuroleptics. Thirty-four psychiatrists made parallel ratings from the perspective of the average patient (individual utility) and of the patient's family and society (institutional utility). Psychiatrists predicted patients' ratings moderately well, but misjudged the bothersomeness to patients of 24% of side effects and 20% of symptoms. When considering the patients' perspective, both schizophrenic patients and psychiatrist rated symptoms as no more bothersome than side effects. However, psychiatrists saw side effects as significantly less bothersome than symptoms when considering costs to society. The subjective utility of neuroleptic medications for schizophrenia is most justifiable from an institutional perspective. (14 references) AA

Address for reprint requests: Mezes Hall 330, University of Texas Austin, Texas 78712

REFERENCE NUMBER 13

Au: Fitten, L. Jaime; Lusky, Richard; Hamann, Claus
Ti: **Assessing Treatment Decision-Making Capacity in Elderly Nursing Home Residents**
So: *Journal of the American Geriatrics Society* 38(10):1097–1104, 1990

Clinicians usually employ indirect measures of cognitive and physical function in order to assess medical decision-making capacity. We tested a reference group of well elderly (Mini-Mental State Exam (MMSE) score = 29.1 + 0.8, mean + SD), for their understanding of three increasingly complex, hypothetical treatment situations or "vignettes"—use of a hypnotic, need for thoracocentesis, and desire for CPR. From this, we have developed a more direct, Guttman-like assessment of decision-making capacity. Of 51 Veterans Affairs nursing home residents (MMSE score = 22.4 + 6.9), only 33.3% demonstrated intact decision-making capacity by this method, whereas 77% were felt by their primary physicians to be capable of giving consent for oral surgery; 37.3% had very impaired decision-making capacity; and 29.4% were intermediate in this ability. Judged against our more direct assessment of decision-making capacity, primary physicians' judgment of capacity for consent was 31% to 39% sensitive in identifying impaired decision-making and the MMSE was 53% to 63% sensitive. These measures were 100% and 82% to 83% specific in identifying intact decision-making capacity respectively. We conclude that (1) more directly assessed decision-making capacity varies noticeably among elderly nursing home residents and correlate in only limited fashion with frequently used cognitive screening methods; and (2) cognitive screening tests underestimate the prevalence of impaired decision-making capacity in this population. For informed consent and advance directives, our study suggests that decision-making capacity should be directly, rather than indirectly, assessed. (28 references) AA

Address for reprint requests: Veterans Affairs Medical Center, 116A–9, 16111 Plummer Street,
Sepulveda, California 91343

REFERENCE NUMBER 14
Au: Fretwell, Marsha D.; Raymond, Patricia M.; McGarvey, Stephen T.; Owens, Norma; Traines, Mark; et al.
Ti: **The Senior Care Study: A Controlled Trial of Consultative/Unit-Based Geriatric Assessment Program in Acute Care**
So: *Journal of the American Geriatrics Society* 38(10):1073–1081, 1990

Successful models of inpatient geriatric assessment have often involved long hospital stays, specialized interdisciplinary care, and prolonged follow-up, which are difficult to achieve within a prospective payment system. A randomized clinical trial was undertaken to evaluate the efficacy (maintenance or improvement in mental, emotional, and physical function) of using a geriatric assessment process in acute hospital care without increasing hospital charges or lengths of stay. Four hundred thirty-six patients= 75 years of age were randomly allocated to treatment (n=221) or control (n=215) conditions. Patients in the treatment group were admitted to a special unit and evaluated on admission by an interdisciplinary team, which developed a care plan. Although primary care was provided by the patient's own physician, the team followed the patients as consultants on the unit in the hospital, and by telephone for 2 months after discharge. The control group was placed on other units and received usual hospital care. The treatment and control groups were similar at study entry. At follow-up, there were no significant differences between the groups with respect to lengths of stay, hospital charges, mortality, change in physical function, or change in mental function. The treatment group changed more often in measured emotional function. This study indicates that it is feasible to implement consultative interdisciplinary team care in the acute-care hospital, but that its efficacy may be limited when applied to an unselected group of older patients. (28 references) AA

Address for reprint requests: Roger Williams General Hospital, 825 Chalkstone Boulevard,
Providence, Rhode Island 02908

REFERENCE NUMBER 15
Au: Galanter, Eugene
Ti: **Utility Functions for Nonmonetary Events**
So: *American Journal of Psychology* 103(4):449–470, 1990

Six experiments are described that use magnitude estimation methods to characterize a nonlinear (approximately square root) utility function for money. These same methods can be used to assign utilities to nonmonetary events and objects. The procedures permit a translation between the utility of such events and their monetary equivalents. The measure represents the incremental utilities of outcomes from a current neutral position. Positive returns grow more slowly than negative in a pessimist's world. These utility measures are consonant with the form of the utility function hypothesized by Kahneman and Tversky (1979). (34 references) AA

Address for reprint requests: Columbia University, 460 Riverside Drive, New York, New York 10027

REFERENCE NUMBER 16
Au: Gelberg, Lillian; Linn, Lawrence S.; Mayer-Oakes, S. Allison
Ti: **Differences in Health Status Between Older and Younger Homeless Adults**
So: *Journal of the American Geriatrics Society* 38(11):1220–1229, 1990

The Institute of Medicine has placed a priority on determining the special health-care needs of elderly homeless persons. As part of a community-based study of 521 homeless adults in two beach communities of Los Angeles, we compared the demographic characteristics and health of older (age range, 50–78, n = 61) and younger (age range, 18–49, n = 460) homeless individuals. Compared with younger adults, older adults were more likely to be white (85% versus 61%), veterans (59% versus 27%), retired (36% versus 3%), and living in a vehicle (21% versus 8%). Older adults were more likely to report having a chronic disease (69% versus 49%), functional disabilities, no informal social contacts during the previous month (49% versus 27%), observed high blood pressure (42% versus 22%), elevated creatinine (11% versus 2%), and elevated cholesterol (57% versus 36%). Older adults were less likely to have a toothache (3% versus 30%), report psychotic symptoms (25% versus 42%), and to be illegal drug users (15% versus 55%). Although they are chronologically younger, the constellation of health and functional problems of older homeless adults resemble those of geriatric persons in the general population. We suggest that geriatricians could play a significant role in training other primary-care providers to evaluate and treat socially isolated older homeless adults in a more comprehensive way than is currently standard in practice (e.g., interdisciplinary team care and emphasis on functional status, rehabilitative medicine, and assessment for sensory impairment. (32 references) AA

Address for reprint requests: 10833 LeConte Avenue, Los Angeles, California 90024–1683

REFERENCE NUMBER 17
Au: Gibbs, Ian; Bradshaw, Jonathan
Ti: **Quality of Life and Charges in Private Old People's Homes in Great Britain**
So: *Social Indicators Research* 23:269–282, 1990

Over half the residents in old people's homes in Britain have their fees wholly or partly paid from the public purse. Understandably, there is considerable concern that the fees charged should be reasonable in the light of the services and facilities provided. In a recent study, local authority registration officers attempted to relate important qualitative features of private homes to the fees they charged. Taken together, these features provide a measure of the quality of life in homes. Results indicate little relationship between the charges made by homes and the measures reflecting the quality of life for residents. On the other hand, however, it was evident that the quality of life was an important consideration when registration officers made an assessment of the reasonablesness of charges in homes. In short, homes assessed adversely and homes judged as charging too much were more likely to be rated poorly. (6 references) AA

Address for reprint requests: University of York, Department of Social Policy and Social Work,
York, Y01 5DD, United Kingdom

REFERENCE NUMBER 18
Au: Halford, W.K.; Cuddihy, S.; Mortimer, R.H.
Ti: **Psychological Stress and Blood Glucose Regulation in Type I Diabetic Patients**
So: *Health Psychology* 9(5):516–528, 1990

Fifteen Type I diabetic patients self-monitored daily mean blood glucose levels (BGL), psychological stress, diet, exercise, and insulin injections for a period of 8 weeks. Separate multiple-regression analyses were conducted for each subject to assess the predictability of BGL from stress reports, independent of the effects of diet, exercise, and insulin self-administration. Considerable individual variability in findings was evident, with stress predicting BGL in a statistically significant manner in 7 of the 15 subjects. Stress had a significant effect on BGL independent of diet, exercise, and insulin administration for each of these 7 subjects. Discussion focused on the problems of measuring the key self-management behaviors influencing BGL and on the possibility that a subgroup of diabetic patients may be BGL stress responders. (38 references) AA

Address for reprint requests: Royal Brisbane Hospital, University of Queensland, Herston, Queensland 4029, Australia

REFERENCE NUMBER 19

Au: Heeren, Th. J.; Lagaay, A.M.; v Beek, W.C.A.; Rooymans, H.G.M.; Hijmans, W.
Ti: **Reference Values for the Mini-Mental State Examination (MMSE) in Octo- and Nonagenarians**
So: *Journal of the American Geriatrics Society* 38(10):1093–1096, 1990

The Mini-Mental State Examination (MMSE) was used in a population survey of all inhabitants of Leiden, the Netherlands, over 85 years (n = 1258). In this paper we report on 532 subjects without neurological or psychiatric disease. Results show that the median score and lowest quartile cut-off score remain high until the tenth decade (median score = 28, lowest quartile cut-off score = 26). Thus age, in itself, is not a major limitation in using the MMSE. In this study a comparatively low level of education (the majority had 6 to 7 years of education) did not affect the results on the MMSE in a negative way, nor did we find an association with the use of psychoactive drugs. (12 references) AA

Address for reprint requests: Department of Psychiatry, University Hospital, Post Office Box 9600, 2300 RC Leiden, The Netherlands

REFERENCE NUMBER 20

Au: Hirsch, Calvin H.; Sommers, Lucia; Olsen, Anna; Mullen, Lisa; Winograd, Carol Hutner
Ti: **The Natural History of Functional Morbidity in Hospitalized Older Patients**
So: *Journal of the American Geriatrics Society* 38(12):1296–1303, 1990

This study provides data on changes in the functional status of older patients that are associated with acute hospitalization. Seventy-one patients over the age of 74 admitted to the medical service of Stanford University Hospital between February and May 1987 received functional assessments covering 7 domains: mobility, transfer, toileting, incontinence, feeding, grooming, and mental status. Assessments were obtained by report from the patients' caregiver (or the patient when he or she lived alone) for 2 weeks before admission; from the patient's nurse on day 2 of hospitalization and on the day before discharge; and again from the caregiver (or patient) 1 week after discharge. The sample had a mean age of 84, covered 37 Diagnostic Related Groups, and had a median length of stay of 8 days. Between baseline and day 2, statistically significant deteriorations occurred for the overall functional score and for the individual scores for mobility, transfer, toileting, feeding, and grooming. None of these scores improved significantly by discharge. In the case of mobility, 65% of the patients experienced a decline in score between baseline and day 2. Between day 2 and discharge, 67% showed no improvement, and another 10% deteriorated further. These data suggest that older patients may experience a burden of new and worsened functional impairment during hospitalization that improves at a much slower rate than the acute illness. An awareness of delayed functional recovery should influence discharge planning for older patients. Greater efforts to prevent functional decline in the hospitalized older patient may be warranted. (15 references) AA

Address for reprint requests: University of California, Davis, Medical Center, Primary Care Center—Room 3107, 2221 Stocktone Boulevard, Sacramento, California 95817

REFERENCE NUMBER 21
Au: Hofstetter, C.R.; Sallis, J. R.; Hovell, M.F.
Ti: **Some Health Dimensions of Self-Efficacy: Analysis of Theoretical Specificity**
So: *Social Science and Medicine* 31(9):1051–1056, 1990

Based on data drawn from a random-digit-dial probability sample of adults in a major American metropolitan area, this study supports the perspective that self-efficacy is domain specific and that outcome efficacy is distinct from self-efficacy. Data were collected by telephone interviewers which were administered by telephone interviews to 525 respondents with a 64.1% completion rate. Sample demographic summary statistics closely approximated population parameters. Five orthogonal factors emerged from analysis of self-efficacy and outcome efficacy items. The five factors represented self-efficacy with regard to nutrition, medical care, exercise, and with a set of neutral control items relating to political behavior, and with the outcome efficacy items for each behavioral domain. Hypotheses relating scores for each factor with a number of behavioral indicators were tested. Only 4 of 125 correlations failed to support hypothesized relationships, lending evidence for the discriminant validity of the self-efficacy dimensions. (15 references) AA

Address for reprint requests: Department of Political Science Health, San Diego State University, San Diego, California 92182

REFERENCE NUMBER 22
Au: Hogg, John R.; Heller, Kenneth
Ti: **A Measure of Relational Competence of Community-Dwelling Elderly**
So: *Psychology and Aging* 5(4):580–588, 1990

A measure of relational competence was developed to assess the skills necessary for peer friendship development among the elderly. Participants were required to respond to a series of social problem vignettes that were constructed to tap empathy, assertion, and role-taking skills. Validation data were collected as part of a larger project designed to establish indigenous, elderly peer-support telephone dyads among low-income, community-dwelling elderly women. Results indicated that the measure of relational competence as determined by judges' ratings of 2 telephone conversations between participants and staff members. The research illustrates the usefulness of moving away from trait conceptions of social competence to a more focused consideration of particular task demands and the skills needed to solve age-linked social problems. (45 references) AA

Address for reprint requests: Kenneth Heller, Department of Psychology, Indiana University, Bloomington, Indiana 47405

REFERENCE NUMBER 23
Au: Joseph, Jill G.; Caumartin, Susan M.; Tal, Margalit; Kirscht, John P.; Kessler, Ronald C., et al.
Ti: **Psychological Functioning in a Cohort of Gay Men at Risk for AIDS: A Three-Year Descriptive Study**
So: *Journal of Nervous and Mental Disease* 178(10):607–615, 1990

This study describes the mental health of a large cohort of gay men participating in the Chicago Multicenter AIDS Cohort Study/Coping and Change Study. Six biannual questionnaires were self-administered between 1984 and 1988. General mental health was determined by the Hopkins Symptom Checklist (HSCL). An abbreviated version of the Center for Epidemiologic Study Depression Scale (CESD–5) and an adapted Diagnostic Interview Schedule (DIS) question also measured depression. Suicidal ideation was assessed by one question in the HSCL. AIDS-specific distress was determined by three subscales specifically developed for this study. While mean HSCL and CESD–5 scores were stable during the observational period, AIDS-specific distress increased over time. The HSCL scores for the cohort were somewhat elevated above general population norms but considerably below psychiatric outpatient norms. Fewer than 12% of the men reported elevated HSCL or CESD–5 scores three or more times. A self-reported episode of depression of two weeks or more, measured by the DIS screening question, was experienced by 40.1% of the sample. Suicidal ideation was reported on three or more visits by 18.8% of the men. The younger members of this cohort exhibit greater general and AIDS-specific distress. Income was inversely associated with general distress. HIV-seropostive participants had generally higher AIDS-specific distress scores than those who were seronegative, but their scores were equivalent on the HSCL and CESD–5. (23 references) AA

Address for reprint requests: Department of Epidemiology, School of Public Health, University of Michigan, 109 Observatory Street, Ann Arbor, Michigan 48109

REFERENCE NUMBER 24
Au: Kaplan, Robert M.
Ti: **Behavior as the Central Outcome in Health Care**
So: *American Psychologist* 45(11):1211–1220, 1990

A predominant justification for health psychology and behavioral medicine is that behavior or environmental conditions affect a biological process. Thus, many investigators focus attention on the effects of behavior on cell pathology and blood chemistry. This article argues that behavioral outcomes are the most important consequences in studies of health care and medicine. These outcomes include longevity, health-related quality of life, and symptomatic complaints. Traditional measures in biomedical science often have limited reliability and validity. Their validity is demonstrated only through relationships with longevity, role performance, behavioral functioning, and symptomatic experience, and these correlations are often modest. A model is proposed to guide future investigations. Biological, environmental, and psychological variables are included in the model as predictors or mediators of behavioral health outcomes. Recognizing that health outcomes are behavioral, directs intervention toward whatever method produces the most health benefit at the lowest cost. (56 references) AA

Address for reprint requests: M–022, School of Medicine University of California, San Diego, La Jolla, California 92093–0622

REFERENCE NUMBER 25
Au: Kaye, Kathryn; Grigsby, Jim; Robbins, Laurence J.; Korzun, Barbara
Ti: **Prediction of Independent Functioning and Behavior Problems in Geriatric Patients**
So: *Journal of the American Geriatrics Society* 38(12):1304–1310, 1990

Folstein's Mini-Mental State Exam, a test assessing the capacity to perform novel and/or repetitive motor tasks (Behavioral Dyscontrol Scale) and a brief measure of working memory, were used in a sample of 50 male Veterans Affairs geriatric clinic patients who ranged in age from 63 to 105 (mean, 80.1). The purpose of this study was to attempt to predict the patients' capacity to regulate their behavior independently. We hypothesized that frontal lobe disorders often impair a patient's ability to function autonomously and that the Behavioral Dyscontrol Scale, a measure of frontal lobe impairment, would best predict the capacity for independent regulation of purposeful behavior. Therefore, we examined the relationship of the Behavioral Dyscontrol Scale with spouses' and caregivers' ratings of patients' independent living skills, and with behaviors that interfere with independent functioning. The results of hierarchical regression analyses indicated that the Behavioral Dyscontrol Scale was the only predictor of functional autonomy and was the best predictor of both impulsivity and apathy among geriatric patients. The Behavioral Dyscontrol Scale appears to assess a different functional domain than do the MMSE and similar measures, which rely heavily on the evaluation of orientation and gross cognitive status. (34 references) AA

Address for reprint requests: Veterans Affairs Medical Center, 1055 Clermont Street, Denver, Colorado 80220

REFERENCE NUMBER 26

Au: Kazis, Lewis E.; Callahan, Leigh F.; Meenan, Robert F.; Pincus, Theodore
Ti: **Health Status Reports in the Care of Patients with Rheumatoid Arthritis**
So: *Journal of Clinical Epidemiology* 43(11):1243–1253, 1990

We examined the use of formal health status reports every 3 months over 1 year in the clinical care of patients with rheumatoid arthritis (RA). The reports consisted of single-page, computer-generated summaries of scores derived from either the AIMS (Arthritis Impact Measurement Scales) or the MHAQ (Modified Health Assessment Questionnaire) health status questionnaires. A total of 1920 subjects from 27 community practice sites were randomly assigned to 3 study groups in each practice: intervention, attention, placebo, and control. Results showed that 55% of the physicians found the reports to be at least moderately useful as an aid to patient management, primarily for improving the doctor-patient relationship. However, no detectable differences among the three groups were seen in terms of medication compliance, number of physician visits, number of referrals, frequency of major medication changes, attitudes towards the physician, patient satisfaction, or change in health status over 1 year. The failure to demonstrate objective benefits of health status reports in this study may be due to physician unfamiliarity with health status scores, failure to link the report with an office visit, the relative stability of clinical status in the subjects over 1 year, and the relatively short time-frame of the study. (30 references) AA

Address for reprint requests: Multipurpose Arthritis Center, Boston University School of Medicine,
80 East Concord Street, Boston, Massachusetts 02118

REFERENCE NUMBER 27

Au: Kramer, Michael S.; MacLellan, Anne-Marie; Ciampi, Antonio; Etezadi-Amoli, Jamshid; Leduc, Denis G.
Ti: **Parents' vs Physicians' Utilities (Values) for Clinical Outcomes in Potentially Bacteremic Children**
So: *Journal of Clinical Epidemiology* 43(12):1319–1325, 1990

Our previous analyses of decision strategies in children 3–24 months with acute-onset fever >39C and no evident bacterial focus of infection indicated that the risks of routine blood cultures (the unnecessary hospitalization and treatment of children who clear their bacteremia spontaneously) outweigh its benefits (the prevention of a few cases with major infectious sequelae). Because those analyses were based on parents' values for beneficial and adverse clinical outcomes, we wished to examine whether those values differed in physicians and, if so, whether the differences were sufficient to change the results of the decision analysis. Using a pre-tested liner analog utility (value) scale, we evaluated 8 potential clinical outcomes in potentially bacteremic children by surveying 121 parents of healthy 3–24-month-old children attending a private pediatric group practice and 57 attending physicians of a tertiary-care children's hospital emergency room. Utilities were based on a 0–1 normalization, where 0 is the utility of the worst outcome (meningitis or other major bacterial infection, plus venipuncture), and 1 the utility of the best outcome (meningitis or other major bacterial infection, plus venipuncture), and were analyzed using a recently developed statistical model of utility. The majority of parents and physicians combined the imputed components of the outcomes (disease, pain of venipuncture, and stress of hospitalization) in a nonlinear fashion. Parents assigned substantially lower utility (i.e., greater disutility) to venipuncture, minor infection, and hospitalization than did physicians, and these utilities were even lower in parents with other children at home. There were no consistent associations between parents' utilities and their age or years of schooling, nor between physicians' utilities and their sex or years of experience. Even based on the physicians' utilities, expected utilities (E(u)s) favored the "no blood culture" strategy (E(u) = 0.994) over "universal blood culture" (E(u) = 0.898) or even "selective blood culture" (blood cultures only in children deemed to be at highest risk of bacteremia) (E(u) = 0.982). Moreover, the result was insensitive to feasible ranges of probability estimates. Unless greater benefits can be demonstrated for the test, our findings suggest that physicians should either obtain fewer blood cultures or develop less aggressive protocols for treating children whose cultures are positive. (26 references) AA

Address for reprint requests: 1020 Pine Avenue West, Montreal, Quebec, Canada H3A 1A2

REFERENCE NUMBER 28

Au: Lederle, Frank A.; Busch, David L.; Mattox, Kimberly M.; West, Melissa J.; Aske, Donna M.
Ti: **Cost-Effective Treatment of Constipation in the Elderly: A Randomized Double-Blind Comparison of Sorbitol and Lactulose**
So: *American Journal of Medicine* 89:597–601, 1990

The purpose of this study was to evaluate the use of sorbitol as an inexpensive alternative to lactulose for treating constipation in the elderly. Patients and Methods: Thirty men aged 65 to 86 with chronic constipation were studied in a randomized, double-blind, cross-over trial in which lactulose and 70% sorbitol (0 to 60 mL daily) were each given for 4 weeks preceded by a 2-week washout period. The average number of bowel movements per week was 6.71 with sorbitol and 7.02 with lactulose (95% confidence interval of the difference: −0.43 to 1.06), and the average number of days per week with bowel movements was 5.23 with sorbitol and 5.31 with lactulose (95% confidence interval of the difference: −0.32 to 0.48). Eleven patients stated a preference of sorbitol, 12 for lactulose, and 7 had no preference. On a visual analogue scale measuring severity of constipation (0 to 100 mm), the average score for sorbitol was 35.6 mm versus 37.1 mm for lactulose (95% confidence interval of the difference: –6.4 to 9.3). The sorbitol and lactulose treatment periods were also similar in percent of bowel movements recorded as "normal," frequency and severity of symptoms such as bloating, cramping, and excessive flatulence, and overall health status as assessed by a previously validated 5-category questionnaire. There were not significant differences between sorbitol and lactulose in any outcome measured except nausea, which was increased with lactulose. These results support the hypothesis that sorbitol and lactulose have no clinically significant differences in laxative effect. Sorbitol can be recommended as a cost-effective alternative to lactulose for the treatment of constipation in the elderly. (26 references) AA

Address for reprint requests: Division of General Internal Medicine (III-O), Department of Medicine, Minneapolis Veterans Affairs Medical Center, One Veterans Drive, Minneapolis, Minnesota 55417

REFERENCE NUMBER 29

Au: Littlefield, Christine H.; Rodin, Gary M.; Murray, Michael A.; Craven, John L.
Ti: **Influence of Functional Impairment and Social Support on Depressive Symptoms in Persons with Diabetes**
So: *Health Psychology* 9(6):737–749, 1990

Testing the buffering model of social support among 158 adults with diabetes, we predicted that, among patients with higher levels of illness-related impairment, adequate social support would act as a buffer against depression. Measures included the Beck Depression Inventory; the Sickness Impact Profile; and an assessment of the adequacy of social support to enable the patient to deal with illness-related tasks, domestic chores, financial responsibilities, and emotional needs. Depressive symptoms correlated positively with functional impairment ($r = .58$, $p < .001$) and negatively with the adequacy of social support ($r = -.31$, $p < .001$). In addition, social support moderated depression in the face of greater impairment such that, among patients who reported the most illness-related functional disabilities, adequate support provided a relative protection from depression. The findings suggest that individuals with inadequate support are most at risk to become depressed when disability related to illness increases. (35 references) AA

Address for reprint requests: Department of Psychology, College Wing 2–306, The Toronto Hospital, 200 Elizabeth Street, Toronto, Ontario, M5G 2C4, Canada

REFERENCE NUMBER 30
Au: Manne, Sharon L.; Zautra, Alex J.
Ti: **Couples Coping with Chronic Illness: Women with Rheumatoid Arthritis and Their Healthy Husbands**
So: *Journal of Behavioral Medicine* 13(4):327–342, 1990

Effects of a chronic disease, rheumatoid arthritis, upon the psychological adjustment of 103 women and their healthy husbands were examined. Husbands completed scales assessing perceived vulnerability to illness and coping efficacy, burden of caring for their wives, and level of psychological adjustment. Wives completed the Ways of Coping scale, rated attributions about arthritis, and rated criticalness and supportiveness of their husbands. Husbands were also interviewed and their responses coded for critical remarks about the wife. The same variables were used to predict each partner's adjustment in order to compare factors associated with each. Hierarchical regression indicated that negative marital interaction surrounding the wife's illness was a determinant of both partners' psychological adjustment. Apart from this variable, different factors predicted husbands' and wives' mental health. Husbands were most affected by their own perceived vulnerability to disease and coping inefficacy. Wives were most affected by pain severity and how they coped with arthritis. (23 references) AA

Address for reprint requests: Department of Psychology, Arizona State University, Tempe, Arizona 85287

REFERENCE NUMBER 31
Au: Masin, Sergio Cesare; Agostini, Anna
Ti: **Time Errors in the Method of Pair Comparisons**
So: *American Journal of Psychology* 103(4):487–494, 1990

Time errors produced by the method of constant stimuli depend on the position of the standard within the range of variable stimuli (asymmetry effect) and on the order of the compared stimuli (presentation-order effect). Both effects were found using the method of pair comparisons. There seem to be one and perhaps two sources of these time errors: (a) greater weighing of the more recent stimulus or response, and (b) assimilation to the immediately preceding response. (13 references) AA

Address for reprint requests: Institute of Philosophy, Pedagogics, and Teaching of Modern Languages, University of Udine, Via Antonini 8, 33100 Udine, Italy

REFERENCE NUMBER 32
Au: Mays, Nicholas B.; Petruckevitch, Ann; Snowdon, Claire
Ti: **Patients' Quality of Life Following Extracorporeal Shock-Wave Lithotripsy and Percutaneous Nephrolithotomy for Renal Calculi**
So: *International Journal of Technology Assessment in Health Care* 6:633–642, 1990

The objective of this study was to test whether the relatively new, noninvasive technique of extracorporeal shock-wave lithotripsy (ESWL) for renal stones resulted in a measurably better outcome from the patients' point of view than percutaneous surgery. The claimed superiority of ESWL was not demonstrated with the data available. (11 references) AA

Address for reprint requests: United Medical and Dental Schools of Guy's and St. Thomas's Hospitals, London, England

REFERENCE NUMBER 33

Au: McCormick, Kathleen A.; Cella, Margot; Engel, Bernard T.
Ti: **Cost-Effectiveness of Treating Incontinence in Severely Mobility-Impaired Long Term Care Residents**
So: *Quality Review Board* (QRB) (Dec.):439–443, 1990

According to Teh-Wei Hu, PhD, Professor of Health Economics, University of California at Berkeley, this paper makes its contribution in demonstrating the costs and effects of using a mechanical lift to improve patients' incontinence. The findings have important implications for long term care services. (17 references) AA

Address for reprint requests: Laboratory of Behavioral Sciences, NIH, Gerontology Research Center, 4940 Eastern Avenue, Baltimore Maryland 21224

REFERENCE NUMBER 34

Au: Meguro, K.; Ueda, M.; Yamaguchi, T.; Sekita, Y.; Yamazaki, H., et al.
Ti: **Disturbance in Daily Sleep/Wake Patterns in Patients with Cognitive Impairment and Decreased Daily Activity**
So: *Journal of the American Geriatrics Society* 38(11):1176–1182, 1990

The sleep/wake patterns of 121 chronically ill, mentally and physically handicapped patients were visually monitored hourly for 14 consecutive days. Four types of sleep/wake patterns were found. In order to investigate how cognitive and physical functions correlated with sleep disorders, patients were classified based on a scale of mental function and the grading of daily activity. The percent of total sleep hours and the sleep rating, showing disturbances in sleep/wake pattern, were evaluated. We found a high degree of individuality in sleep/wake patterns. Sleep disturbance was associated with daily activity as well as with cognitive impairment. This monitoring system provides medical personnel with valuable information for clinical management. (23 references) AA

Address for reprint requests: Department of Geriatric Medicine, Tohoku University School of Medicine, 1–1, Seiryo-Machi, Aoba-ku, 980 Sendai, Japan

REFERENCE NUMBER 35

Au: Mehrez, Abraham; Gafni, Amiram
Ti: **Evaluating Health Related Quality of Life: An Indifference Curve Interpretation for the Time Trade-Off Technique**
So: *Social Science and Medicine* 31(11):1281–1283, 1990

A commonly used method of measuring cardinal preferences for the purpose of evaluating health related quality of life is the time trade-off (TTO) technique. The TTO technique, although offered as a substitute to the standard gamble (SG) technique, is not related in a general way to any existing behavioral theory. We suggest that in the context of value function theory the TTO technique is a method which enables us to identify different points on an individual's indifference curve in his evaluation space. Creating a formal theoretical foundation for the TTO technique enables us to better understand and interpret the outcome of our measurements. We show, for example, that the current way of calculating the value preference of a given health state assumes a very specific set of value functions. This assumption has not been validated in empirical studies and thus casts doubt upon the interpretation of these values as being the value preferences of individuals for these health states. (20 references) AA

Address for reprint requests: Amiram Gafni, Department of Clinical Epidemiology and Biostatistics, (Room 2C12A), Health Sciences Center, McMaster University, 1200 Main Street West, Hamilton, Ontario, Canada L8N 3Z5

REFERENCE NUMBER 36

Au: Mehrez, Abraham; Gafni, Amiram
Ti: **Resource Allocation, Equity and Public Risk: Dying One at a Time vs Dying All Together**
So: *Socio-Economic Planning Sciences* 24(4):285–294, 1990

This paper focuses on the evaluation, from an individual and societal perspective, of risk in terms of possible loss of life due to an exposure to 2 different types of events over a period of time. The 2 types are risk of death from a catastrophic event (a sudden death of many people in a disaster at a yet unknown point in time) expected to occur during a planning period, or risk of death from another event (e.g., disease, road accident, etc.) which claims fewer lives each year, but for which the expected total number of deaths over the planning period is equal to the expected number of deaths from the catastrophic event. Our analysis considers the extreme case in which these two types of events have the same probabilities of death every year and the same expected number of fatalities over the planning period. The individual's decision problem is described using a von-Neumann Morgenstern (vNM) utility function. The model suggests that the choice between these types of events depends on the value of the following variables: the probability of death over the planning period, the length of the planning period, the individual's time preference pattern, and the utility of being in different anxiety states. Stochastic extensions that may direct the public decision-making process (involving aggregated preferences) are discussed. We also discuss issues of implementation. (39 references) AA

Address for reprint requests: Amiram Gafni, Department of Clinical Epidemiology and Biostatistics, (Room 2C12A) McMaster University, 1200 Main Street West Hamilton, Ontario, Canada L8N 3Z5

REFERENCE NUMBER 37

Au: Montgomery, George K.; Reynolds, Norman C. Jr.
Ti: **Compliance, Reliability, Validity of Self-Monitoring for Physical Disturbance of Parkinson's Disease: The Parkinson's Symptom Diary**
So: *Journal of Nervous and Mental Disease* 178(10):636–641, 1990

Previous clinical research in Parkinson's disease has recognized the value of self-monitoring procedures in which patients observe and record the frequency and severity of their own symptoms as these occur within the patient's social and work environment. We discuss issues of methodology and report a study of compliance, test-retest reliability, and validity with a new self-monitoring instrument, the Parkinson's Symptom Diary. Two recordings of frequency (loss of balance, hesitation-freezing) and two ratings of severity (tremor, difficulty walking) were made 4 times daily for 1 week by patients (N=73) who were without apparent loss of cognitive or memory functions. A total of 91% of the diaries received (97% of requested) met strict compliance criteria so that independent sampling over days could be assumed. Test-retest stability over 1 month was demonstrated for each score (all Spearman rho >.85) in a representative subsample of 28 patients. Criterion validity was demonstrated for each score by an expected pattern or correlation with independently obtained observer ratings of the same or related indices of disease, and by comparison with Hoehn and Yahr disability stages. By its simplicity, this self-assessment device can be an invaluable complement to traditional methods of clinical and laboratory assessment in the care and evaluation of Parkinson patients. (14 references) AA

Address for reprint requests: Neuropsychology Service, Sister Kenny Institute, 800 East 28th Street, Minneapolis, Minnesota 55407

REFERENCE NUMBER 38

Au: Nelson, Eugene C.; Landgraf, Jeanne M.; Hays, Ron D.; Wasson, John H.; Kirk, John W.
Ti: **The Functional Status of Patients: How Can It Be Measured in Physicians' Offices?**
So: *Medical Care* 28(12):1111–1126, 1990

Physicians wishing to maintain the functional capacity of their patients often need, but usually do not have, practical measures of function. The Dartmouth COOP, a primary care research network, developed 9 pictorial charts to efficiently measure patient function in a busy office practice. Each chart has a 5-point scale, is illustrated, and can be self-administered of administered by office staff. The Charts are used to measure the patients' overall functional health just as Snellen Charts are used to measure vision. Studies to assess the Charts' reliability, validity, acceptability, and clinical utility were conducted on over 2000 patients in 4 diverse clinical settings. Results show that the Charts are reliable and valid. One-hour test-retest intraclass correlations for elderly patients ranged from 0.78 to 0.98 and from 0.73 to 0.98 for low-income patients. The average Pearson product-moment correlation between Charts and previously validated measures of function was 0.61 and the Charts were as capable of detecting the association between disease and functioning as were longer, standard measures. Most clinicians and patients report that the Charts are easy to use and provide a valuable tool to measure overall function in busy office practice. For the 25% of patients in which the Charts uncovered new information, changes in clinical management were initiated for 40% of them. We conclude that the COOP Charts are practical, reliable, valid, sensitive to the effects of disease, and useful for quickly measuring patient function. (29 references) AA

Address for reprint requests: John Wasson, Department of Community and Family Medicine, Dartmouth Medical School, Hanover, New Hampshire 03756

REFERENCE NUMBER 39

Au: Ouellette-Kuntz, Helene
Ti: **A Pilot Study in the Use of the Quality of Life Interview Schedule**
So: *Social Indicators Research* 23:283–298, 1990

The purpose of this study was to refine the Quality of Life Interview Schedule (QUOLIS) approach to measuring the quality of life of developmentally handicapped adults who are unable to complete a written questionnaire or a verbal interview. Emphasis was placed on the evaluation of intra- and inter-rater agreement. Ten interviews were conducted. Informants were primarily parents and residential counselors. The results indicate that the QUOLIS approach is generally acceptable to informants, the rating scales are sensitive, and the majority of scores have substantial to almost perfect correlations of intra- and inter-rater agreement. (43 references) AA

Address for reprint requests: Department of Community, Health and Epidemiology, Queen's University at Kingston, Kingston, Ontario, Canada K7L 3N6

REFERENCE NUMBER 40

Au: Parkerson, George R. Jr.; Broadhead, W.E.; Tse, Chiu-Kit J.
Ti: **The Duke Health Profile: A 17-Item Measure of Health and Dysfunction**
So: *Medical Care* 28(11):1056–1072, 1990

The Duke Health Profile (DUKE) is a 17-item generic self-report instrument containing 6 health measures (physical, mental, social, general, perceived health, and self-esteem), and 4 dysfunction measures (anxiety, depression, pain, and disability). Items were derived from the 63-item Duke-UNC Health Profile, based upon face validity and item-remember correlations. The study population included 683 primary care adult patients. Reliability was supported by Cronbach's alphas (0.55 to 0.78) and test-retest correlations (0.30 to 0.78). Convergent and discriminant validity were demonstrated by score correlations between the DUKE and the Sickness Impact Profile, the Tennessee Self-Concept Scale, and the Zung Self-Rating Depression Scale. Clinical validity was supported by differences between the health scores of patients with clinically different health problems. Patients with painful physical problems had a DUKE physical health mean score of 58.1, while patients with only health maintenance problems had a mean score of 83.9 (scale: 0.0 = poorest health and 100.0 = best health). Patients with mental health problems had a DUKE mental health mean score of 49.2, in contrast to 75.7 for patients with painful physical problems and 79.2 for those with health maintenance. The DUKE is presented as a brief technique for measuring health as an outcome of medical intervention and health promotion. (29 references) AA

Address for reprint requests: Box 2914, Duke University Medical Center, Durham, North Carolina 27710

REFERENCE NUMBER 41

Au: Prigatano, George P.; Altman, Irwin M.
Ti: **Impaired Awareness of Behavioral Limitations After Traumatic Brain Injury**
So: *Archives of Physical Medicine and Rehabilitation* 71:1058–1063, 1990

Sixty-four traumatically brain-injured patients were divided into 3 groups. Patients in Group I overestimated their behavioral competencies. Patients in Group II showed behavioral ratings similar to relatives' reports concerning behavioral competencies. Group I patients had greater evidence of bilateral and multiple-site lesions than Groups II and III patients. Speed of left-hand finger tapping was also worse in Group I than Groups II and III, but other standard neuropsychologic test findings failed to separate the groups. Specific brain lesion sites were not related to group membership. Impaired awareness of behavioral limitations after traumatic brain injury may be related to neuropsychologic changes not measured by standard tests. Bilateral impairment of heteromodal cortex may be important to this phenomenon when it exists several months or years postinjury. (33 references) AA

Address for reprint requests: Barrow Neurological Institute, 350 West Thomas Road, Phoenix, Arizona 85013

REFERENCE NUMBER 42

Au: Pumariega, Andres J.; Breiger, David; Pearson, Deborah; Dreyer, Charles; Seilheimer, Daniel K.
Ti: **Behavioral Symptoms in Cystic Fibrosis vs. Neurological Patients**
So: *Psychosomatics* 31(4):405–409, 1990

In this study, the authors compared the adaptation of a group of patients with cystic fibrosis (CF) (N = 46; mean age = 10.91 years) to a similar group of patients who attended a neurological clinic (N = 71; mean age = 10.47). Both groups were assessed using the Child Behavior Checklist by Achenbach (parent version). CF patients demonstrated significantly less psychosocial morbidity than the neurological patients. This was true for overall behavioral symptoms, externalizing and internalizing symptoms, and social competence. The findings indicate better adaptation by the CF group and further support the literature indicating better adaptation in CF patients over other chronically ill groups. Possible reasons for such findings are discussed. (13 references) AA

Address for reprint requests: Child and Adolescent Psychiatry, University of Texas Medical Branch at Galveston, Texas 77550–2774

REFERENCE NUMBER 43
Au: Reuben, David B.; Siu, Albert L.
Ti: **An Objective Measure of Physical Function of Elderly Outpatients**
So: *Journal of the American Geriatrics Society* 38:1105–1112, 1990

Direct observation of physical function has the advantage of providing an objective, quantifiable measure of functional capabilities. We have developed the Physical Performance Test (PPT), which assesses multiple domains of physical function using observed performance of tasks that simulate activities of daily living of various degrees of difficulty. Two versions are presented: a nine-item scale that includes writing a sentence, simulated eating, turning 360 degrees, putting on and removing a jacket, lifting a book and putting it on a shelf, picking up a penny from the floor, a 50-foot walk test, and climbing stairs (scored as 2 items); and a 7-item scale that does not include stairs. The PPT can be completed in less than 10 minutes and requires only a few simple props. We then tested the validity of PPT using 183 subjects (mean age, 79 years) in 6 settings including 4 clinical practices (1 of Parkinson's disease patients), a board-and-care home, and a senior citizens' apartment. The PPT was reliable (Cronbach's alpha= 0.87 and 0.79, inter-rater reliability = 0.99 and 0.93 for the 9-item and seven-item tests, respectively) and demonstrated concurrent validity with self-reported measures of physical function. Scores on the PPT for both scales were highly correlated (0.50 to 0.80) with modified Rosow-Breslau, Instrumental and Basic Activities of Daily Living scales, and Tinetti gait score. Scores on the PPT were more moderately correlated with self-reported health status, cognitive status, and mental health (0.24 to 0.47), and negatively with age (-0.24 and -0.18). Thus, the PPT also demonstrated construct validity. The PPT is a promising objective measurement of physical function, but its clinical and research value for screening, monitoring, and prediction will have to be determined. (16 references) AA

Address for reprint requests: UCLA School of Medicine 32-144 CHS, 10833 Le Conte Avenue,
Los Angeles, California 90024–1687

REFERENCE NUMBER 44
Au: Rogers, Andrei; Rogers, Richard G.; Belanger, Alain
Ti: **Longer Life But Worse Health? Measurement and Dynamics**
So: *Gerontologist* 30(5):640–649, 1990

A number of recent cross-sectional studies of longevity and health among the elderly have concluded that recent positive trends in the prolongation of life have not been matched by similar trends in the extension of healthy life. This paper challenges that pessimistic conclusion by examining conceptual issues related to the measurement and dynamics of the mortality-disability process. It uses data from the 1986 Longitudinal Study of Aging (U.S. Department of Health and Human Services, 1988) to illustrate its principal points. (28 references) AA

Address for reprint requests: Population Program, University of Colorado, Campus Box 484,
Boulder, Colorado 80309

REFERENCE NUMBER 45
Au: Rudman, Daniel; Abbasi, Adil A.; Tourky, Gamil M.; Rudman, Inge W.; Mattson, Dale E.
Ti: **Easily Measurable Adverse Outcome Indicators in a Veterans Affairs Nursing Home**
So: *QRB (Quality Review Bulletin)* 16:257–263, 1990

This study used alternative forms of expression for the 4 types of adverse physical outcomes in question: death, undernutrition, skin breakdown, and deterioration of activities of daily living. The result was a profile of 17 indicator variables, which included prevalences, incidences, and rates of change and which were calculated as percentages or means. The standard error of each percentage or mean was calculated.

The amount of staff time required to obtain the score and the interrater reliability coefficient were calculated for each scoring procedure. (53 references) AA

Address for reprint requests: VA Medical Center, 5000 West National Avenue, Milwaukee, Wisconsin 53295

REFERENCE NUMBER 46

Au: Salive, Marcel E.; Mayfield, Jennifer A.; Weissman, Norman W.
Ti: **Patient Outcomes Research Teams and the Agency for Health Care Policy and Research**
So: *Health Services Research* 25(5):697–708, 1990

For over 20 years the Agency for Health Care Policy and Research (AHCPR) and its predecessor, the National Center for Health Services Research and Health Care Technology Assessment (NCHSR), have supported research on the quality of health care. The Agency for Health Care Policy and Research was established by Congress as the eighth agency of the U.S. Public Health Service (PHS), to highlight a new emphasis on medical effectiveness research (PL 101–239). In carrying out the law, the Department of Health and Human Services created the Medical Treatment Effectiveness Program (MEDTEP), which is coordinated by AHCPR but also involves other agencies of the PHS, the Health Care Financing Administration (HCFA), and other governmental entities. MEDTEP expands upon and joins several earlier programs: NCHSR's (1988) Patient Outcome Assessment Research Program, HCFA's Medical Treatment Effectiveness Initiative (Roper et al. 1988), and the congressional emphasis on the development of practice guidelines (Agency for Health Care Policy and Research 1990). MEDTEP consists of 4 elements: medical treatment effectiveness research, development of data bases for such research development of clinical guidelines, and the dissemination of research findings and clinical guidelines. (39 references) AA

Address for reprint requests: Epidemiology, Demography and Biometry Program, National Institute on Aging, National Institutes of Health, 7550 Wisconsin Avenue, Room 612, Bethesda, Maryland 20892

REFERENCE NUMBER 47

Au: Sampalis, John S.; Pouchot, Jacques; Beaudet, Francois; Carette, Simon; Gutkowski, Andrzej
Ti: **Arthritis Impact Measurement Scales: Reliability of a French Version and Validity in Adult Still's Disease**
So: *Journal of Rheumatology* 17(12):1657–1661, 1990

The Arthritis Impact Measurement Scales (AIMS) questionnaire was administered to 57 patients with adult Still's disease (ASD) and 104 controls. Six of the 9 scales were consistent for both groups (Cronbach's (alpha ≥. 0.70). Two scales, Mobility and Dexterity, were consistent for ASD only (alpha ≥. 0.70). The reliability of a French version of the AIMS was similar to the standard AIMS. Of the 13 associations evaluating criterion-related validity of the AIMS in ASD, 11 were statistically significant. We conclude that the French and standard AIMS are comparable and that this questionnaire is reliable and valid for assessing outcomes in ASD. (14 references) AA

Address for reprint requests: The Montreal General Hospital, 1650 Cedar Avenue, Montreal, PQ Canada H3G 1A4

REFERENCE NUMBER 48

Au: Sharpe, M.; Hawton, K.; House, A.; Molyneux, A.; Sandercock, P., et al.
Ti: **Mood Disorders in Long-Term Survivors of Stroke: Associations with Brain Lesion Location and Volume**
So: *Psychological Medicine* 20(4):815–828, 1990

Sixty surviving patients from a community-based stroke register who had CT scan evidence of a single brain lesion and neurological signs appropriate to it were interviewed 3 to 5 years following their first-ever stroke. Mood disorder (anxiety and depression), physical disability, and intellectual impairment were assessed using standardized measures. The position and volume of the brain lesion was determined from CT scans performed soon after the stroke. The prevalence of depressive disorder was lower in this sample than that reported in previous studies (DSM-IIR major depression 8.3%; all DSM-IIIR depressive disorders 18.3%). Reports by other workers for an association of depressive disorder either with left-sided brain lesions or with anteriorly placed lesions in the left cerebral hemisphere were not supported. Neither was there evidence of a correlation between symptom score and proximity of the lesion to the anterior pole of the left cerebral hemisphere. Psychiatric symptom scores were however greater with larger volume brain lesions. Anxiety disorders, especially agoraphobia, were relatively common (20% if diagnosed in the presence of depressive disorder), but were not related to lesion location or volume. (42 references) AA

Address for reprint requests: University Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX England

REFERENCE NUMBER 49

Au: Shmotkin, Dov
Ti: **Subjective Well-Being as a Function of Age and Gender: A Multivariate Look for Differentiated Trends**
So: *Social Indicators Research* 23:201–230, 1990

Studies on subjective well-being (SWB) suggest that its cognitive aspect, or life satisfaction, is positively correlated with age, whereas its affective aspect, often separated into positive affect (PA) and negative affect (NA) is negatively correlated with age. Gender differences in SWB are usually small. The present study attempted to explore these trends in an Israeli sample of 447 community-dwelling people aged 21 to 87, with special reference to relatively unattended issues as the effect of control variables on the affective aspect and the feasible age by gender interaction in SWB. The results showed that Cantril's Self-Anchoring Scale (SAS), Bradburn's Affect Balance Scale (ABS), and Neugarten et al.'s Life Satisfaction Index A (LSIA) were all significantly and negatively corrected with age. No significant gender differences emerged, but a significant age-by-gender interaction was found in SAS and LSIA. Controlling for personal variables (education, health, place of birth, and marital status) could wipe out the age effects on SAS and LSIA, but not on ABS. By the same procedure, the age-by-gender interaction could be wiped out in SAS and substantially reduced in LSIA. The age effect on ABS was mainly due to PA, rather than NA. The results indicate the differential impact of personal variables on the aspects of SWB. Refering to the Israeli context, it seems that both cohort- and aging-related variables account for the decline of life satisfaction in the older subjects. Age-associated decline of affect is apparently connected to some other adaptive mechanisms, which regulate both positive and negative affect in old age. (69 references) AA

Address for reprint requests: Department of Psychology, Tel-Aviv University Ramat-AVIV 69978 Israel

REFERENCE NUMBER 50
Au: Sibley, John T.; Blocka, Kenneth L.N.; Haga, May; Martin, Wendy A.; Murray, Lou M.
Ti: **Clinical Course and Predictors of Length of Stay in Hospitalized Patients with Rheumatoid Arthritis**
So: *Journal of Rheumatology* 17(12):1623–1627, 1990

Patients admitted for therapy of active rheumatoid arthritis were prospectively followed throughout their hospital stay. Average length of stay was 17.1 days. Serial global assessments, whether determined by rheumatologist, physiotherapist, or patient, appeared to improve linearly until at least hospital day 21. From admission to discharge, mean global assessment scores improved by about one third. Poor global assessment, high disability index, and the presence of comorbid disease and anemia on admission, as well as admission late in the week, were predictive of prolonged hospital stay. (18 references) AA

Address for reprint requests: University Hospital, Saskatoon, SK, Canada S7N OXO.

REFERENCE NUMBER 51
Au: Siu, Albert L.; Reuben, David B.; Hays, Ron D.
Ti: **Hierarchical Measures of Physical Function in Ambulatory Geriatrics**
So: *Journal of Geriatrics Society* 38:1113–1119, 1990

Brief and uncomplicated methods for obtaining information on functional status would facilitate the assessment of older patients. We evaluated the potential usefulness, reliability, and validity of 4 hierarchical measures of physical function in 123 elderly subjects seen in 4 ambulatory geriatrics settings. Although the vast majority (83.2%) of subjects were fully independent on the Katz Activities of Daily Living Scale, a broader scope of functional difficulty was reported on the Spector-Katz, 5-item OARS, and Rosow-Breslau scales. The 3 scales all had either borderline or more acceptable coefficient of scalability (0.57–0.77); the hierarchical order of items was not observed in 5.3% to 13.6% of subjects. Combining items from these established measures resulted in 2 new scales with acceptable scalability and construct validity; however, some errors in item order persisted. Although their ease of administration is clearly advantageous, clinicians using short hierarchical scales to assess functional status of older patients should be aware of their limitations. (23 references) AA

Address for reprint requests: Division of Geriatrics UCLA Department of Medicine, A-671 Factor Building, Los Angeles, California 90024-1687

REFERENCE NUMBER 52
Au: Smith, Timothy W.; Peck, Judith R.; Ward, John R.
Ti: **Helplessness and Depression in Rheumatoid Arthritis**
So: *Health Psychology* 9(4):377–389, 1990

Depression is common in rheumatoid arthritis (RA) populations and has been hypothesized to result from patients' belief that they cannot control their disease or its impact. In a sample of 106 patients with RA, we found that scores on a measure of helplessness mediated the relationship between severe, disabling RA and depression. Further, this association was independent of the previously demonstrated correlation between cognitive distortion and depression in RA patients. Thus, both helplessness and cognitive distortion may be important factors in the development and treatment of depression among RA patients. (46 references) AA

Address for reprint requests: Department of Psychology, Behavioral Sciences Building, University of Utah, Salt Lake City, Utah 84112

REFERENCE NUMBER 53

Au: Stein, Ruth E.K.; Jessop, Dorothy Jones
Ti: **Functional Status II(R): A Measure of Child Health Status**
So: *Medical Care* 28(11):1041–1055, 1990

Few measures are available to assess the health status of the growing numbers of children who now survive long-term with chronic physical disorders. A Functional Status Measure, FS I, that had considerable promise for measuring individual child health status and characterizing populations was developed in 1978. This paper describes a revised version of that measure. Data were collected using a new sample of 732 children (aged 0 to 16 years) with and without chronic physical conditions in order to assess psychometric properties of the new instrument. The FSII(R) has both a long (43-item) and a short (14-item) version. The long version has a total score derived from a 1 factor solution and a 2 factor solution consisting of General Health and Stage Specific factors for each age group. The 14-item version of FSII(R) uses a common core of items across the entire age span. Internal consistency estimates (alphas) for the factor-based and 14-item versions are all >0.80. At each age, long and short versions behave similarly in a wide range of tests of discriminant, construct, and content validity-strong support that they constitute a common measure. The FS II(R) has excellent psychometric properties and provides concise measures of health status of children spanning the entire childhood age range from 0 to 16 years. It has particular strengths for the measurement of health status of children with chronic physical conditions who are not disabled. (35 references) AA

Address for reprint requests: Department of Pediatrics, Albert Einstein College of Medicine, Bronx, New York 10461

REFERENCE NUMBER 54

Au: Tennstedt, Sharon L.; Sullivan, Lisa M.; McKinlay, John B.; D'Agostino, Ralph B.
Ti: **How Important Is Functional Status as a Predictor of Service Use by Older People?**
So: *Journal of Aging and Health* 2(4):439-461, 1990

In studies of older people, it is often assumed that biophysical, or functional, status is the primary determinant of formal service use. This article reports baseline data from a longitudinal study of a community-based, linked random sample of frail elders (n=635) and their informal caregivers (n=429) to investigate the relative contribution of social circumstances to the use of community-based formal services. Elder respondents were categorized into three groups defined by their primary source of care: (a) informal only, (b) mixed help with predominantly informal care, (c) mixed help with predominantly formal services. Of the respondents, 79% received most of their help from informal caregivers, whereas 21% relied on formal services for most of their assistance. A series of logistic regression models were developed to identify variables that discriminated between major sources of care. The social factor of living alone is the consistent predictor of reliance on formal services. Only for those elders living alone does the physical factor of level of frailty predict reliance on formal services. Elders who live with a caregiver, particularly a spouse, are likely not to use any formal services regardless of their level of frailty. Finally, elders reliant on formal services receive much less care overall. (41 references) AA

Address for reprint requests: New England Research Institute, 9 Galen Street, Watertown, Massachusetts 02172

REFERENCE NUMBER 55
Au: Teno, Joan; Kiel, Douglas P.; Mor, Vincent
Ti: **Multiple Stumbles: A Risk Factor for Falls in Community-Dwelling Elderly**
So: *Journal of the American Geriatrics Society* 38:1321–1325, 1990

To better understand risk factors for falls among community-dwelling elderly, we analyzed data from a sample of elderly Medicare beneficiaries interviewed in 1987 and a year later. Demographic, social, medical, and functional information were obtained by telephone interview with 736 subjects (68% women) whose average age was 76.5 (range, 65–99). At baseline, 63 subjects reported a fall in the past month. At the second interview follow-up information on falls in the past year was obtained on 586 subjects. One hundred twenty-seven (22%) subjects reported one or more falls. Baseline risk factors that were independent predictors of a fall at the second interview included 2 or more stumbles (adjusted odds ratio (AOR) 2.3, 95% confidence interval (CI), 1.2–4.5), one or more falls (AOR 5.9, 95% CI 2.9–12.2), having spent 4 or more days in bed in the past month (AOR 7.7, 95% CI 1.9–31.0), and self-reported declining health status (AOR 2.0, 95% CI 1.1–3.5). Falls and stumbles are prevalent among community- dwelling elderly. After controlling for covariates, we found subjects who reported 2 or more stumbles in the past month are at increased risk for a fall in the following year. (26 references) AA

Address for reprint requests: Division for Aging Studies and Services, 2150 Pennsylvania Avenue NW, Washington, DC 20037

REFERENCE NUMBER 56
Au: Thompson, Mark G.; Heller, Kenneth
Ti: **Facets of Support Related to Well-Being: Quantitative Social Isolation and Perceived Family Support in a Sample of Elderly Women**
So: *Psychology and Aging* 5(4):535–544, 1990

The purpose of this study was to examine the independent and interactive relationships of measures of network embeddedness and perceived social support with mental and physical health measures from responses of a sample of 271 community-dwelling elderly women. Quantitative social isolation was measured as the co-occurrence of low network embeddedness with family and with friends. There was a threshold effect such that quantitatively isolated participants had poorer psychological well-being and functional health than did nonisolated participants. This effect was independent of perceived support levels. The pattern was different for perceived social support. Elderly women with low perceived family support had poorer psychological well-being regardless of perceived support from friends or network embeddedness. Implications are discussed for several unanswered questions in the social support literature, including possible interventions for the quantitatively isolated and for those with low levels of perceived support. (59 references) AA

Address for reprint requests: Department of Psychology, Indiana University, Bloomington,
Indiana 47405

REFERENCE NUMBER 57
Au: Thorslund, Mats; Warneryd, Bo
Ti: **Surveying the Elderly About Health, Medical Care and Living Conditions. Some Issues of Response Inconsistency**
So: *Archives of Gerontology and Geriatrics* 11:161–173, 1990

A sample of elderly persons (75–84 years old) in Sweden was surveyed twice on home conditions, health, and medical care. Two data collection methods were used: interviews and a mail survey. It has been shown that it is possible to carry out a mail survey (with low non-response) among the elderly in this group. However, what about other aspects of quality? Is it really possible to use a mail survey instead of the much more expensive and complicated techniques involved in interviewing? The results show that for certain groups of variables there are fairly large differences between how respondents reply in the mail survey and in personal interviews carried out by district nurses. These differences apply both to the degree of inconsistency in answers and to shifts in marginal distributions. Among other things, more ailments are mentioned at interview. The demand for information on the elderly and the differences between the methods in the cost of gathering this information make reliability and validity studies of methods of surveying the elderly increasingly important. (23 references) AA

Address for reprint requests: Department of Social Medicine University Hospital, Uppsala, Sweden and Statistics Sweden, Stockholm , Sweden

REFERENCE NUMBER 58

Au: Trumbull, William N.
Ti: **Reply to Whittington and MacRae**
So: *Journal of Policy Analysis and Management* 9(4):548–550, 1990

In this article, the author responds to criticisms of an earlier article that discussed the relevance of "standing" in cost-benefit analysis. Three issues are discussed: (1) the Pareto principle; (2) recognition of benefits and costs of foreigners and of criminals; and (3) the role of cost-benefit analysis beyond that of pure efficiency concerns. (0 references) CH–P

Address for reprint requests: Economics Department West Virginia University, Morgantown, West Virginia

REFERENCE NUMBER 59

Au: Ward, Harold W.; Ramsdell, Joe W.; Jackson, J. Edward; Renvall, Marian; Swart, Jo Anne
Ti: **Cognitive Function Testing in Comprehensive Geriatric Assessment**
So: *Journal of the American Geriatrics Society* 38:1088–1092, 1990

Tests of cognitive function are frequently used in geriatric assessment, but the effect of test setting has rarely been explored. To determine the effect of testing site on the performance of elderly patients undergoing a comprehensive geriatric assessment, we administered the Mini-Mental State Exam to 116 geriatric patients in the clinic and at their residence. Their cognitive abilities varied from normal to severely impaired. The patients' scores were 1.5 + 3.6 (mean + SD) higher at their residence. The clinical importance of a difference in score of 1.5 is not clear. For this reason a second analysis was performed in which a difference in scores of 5 points or greater between settings was considered clinically meaningful. Twenty-five percent (29 of 116) differed by 5 points or more. Of these 29 patients, 22 (76%) tested better in the residential setting. These differences were statistically significant (P = .001). We conclude that the testing site may affect test performance and that in-home assessment may reveal the optimal cognitive function of geriatric patients. (12 references) AA

Address for reprint requests: Joe W. Ramis Hall, USCD Medical Center, 225 Dickinson Street, San Diego, California 92103

REFERENCE NUMBER 60

Au: Wells, Kenneth B.; Manning, Willard G. Jr.; Valdez, R. Burciaga
Ti: **The Effects of a Prepaid Group Practice on Mental Health Outcomes**
So: *Health Services Research* 615–625, 1990

Does a prepaid group practice relative to comparable fee-for-service plans lead to different mental health outcomes for its beneficiaries? To answer this question, we used data from the RAND Health Insurance Experiment. We observed no statistically significant or clinically meaningful differences in mental health outcomes for families randomly assigned to Group Health Cooperative of Puget Sound or to comparable fee-for-service insurance plans in the Seattle area. We found the same null result for overall mental health status as well as for psychological distress (e.g., anxiety and depression) and psychological well-being, and for the full population as well as the initially sick and poor, although our precision was low for the latter comparisons. Thus, the less intensive style of treatment in the prepaid group practice was not associated with noticeably worse mental health outcomes. (25 references) AA

Address for reprint requests: The Rand Corporation, 1700 Main Street, Santa Monica, California 90406

REFERENCE NUMBER 61

Au: Wennberg, John E.
Ti: **On the Status of the Prostate Disease Assessment Team**
So: *Health Services Research* 25(5):709–716, 1990

This article discusses the background and conceptual framework that supports the Patient Outcome Research Team (PORT) study on prostate disease. Results from this assessment activity were first published in 1988 in a series of articles in the Journal of the American Medical Association. Part of the findings indicated that patients should be more actively involved in their treatment. This result has led to the development of a "shared decision-making procedure." This PORT team is also working with the American Urologic Association to examine outcomes associated with transurethral prostatectomy. (5 references) CH–P

Address for reprint requests: Dartmouth Medical School, Hanover, New Hampshire 03756

REFERENCE NUMBER 62

Au: Williams, Mark E.; Gaylord, Susan A.; McGaghie, William C.
Ti: **Timed Manual Performance in a Community Elderly Population**
So: *Journal of the American Geriatrics Society* 38:1120–1126, 1990

The extent of functional disability measured by performance of a series of simple manual tasks was determined in 1,286 elderly people, aged 66 to 98, who resided in central North Carolina. Missing data left 1,106 subjects for analysis. Poor manual performance was defined by either of 2 criteria: (1) inability to complete all the test items, or (2) taking longer than 350 seconds to complete the test. Using the first criterion, 113 persons (10.2%) were poor performers. When the 2 writing items were omitted from the analysis, 28 persons (2.4%) were in the poor performance group. Of the 993 persons who completed all items, 59 persons (5.9%) performed poorly. Using both criteria, the extent of functional disability was 16.1%; excluding the writing items, the extent of poor performance was 8.3%. Compared to those who performed well, those who performed poorly were older, poorer, less educated, more likely to be black, and less healthy. Because manual ability correlates highly with functional dependency and identifies those at risk for increased care needs, the magnitude of manual dysfunction noted in this survey has important implications for care providers and policy-makers. (18 references) AA

Address for reprint requests: University of North Carolina, Chapel Hill, North Carolina 27599–7550

REFERENCE NUMBER 63

Au: Whittington, Dale; MacRae, Duncan Jr.
Ti: **Comment: Judgments About Who Has Standing in Cost-Benefit Analysis**
So: *Journal of Policy Analysis and Management* 9(4):536-547, 1990

The authors critique an earlier article by W. Turnbull that discusses who should be counted, i.e., who has "standing," in a cost-benefit analysis. Turnbull argues that standing can be settled by reference to the potential Pareto principle. Whittington and MacRae disagree. In this article they expand on their previously stated position. (0 references) CH–P

Address for reprint requests: information not available.

Professional Journals Reviewed

Articles cited in the ANNOTATIONS Section have been identified from a set of journals that are routinely reviewed by the Clearinghouse staff. Each new issue is examined for book reviews, current research funding opportunities, and forthcoming conferences, as well as relevant articles. Journal titles along with the volume and issue number reviewed for this issue of the *Bibliography on Health Indexes* are listed below.

ABS-American Behavioral Scientist	34(1)(2)
Acta Psychiatrica Scandinavica	82(4–6)
American Economic Review	78(4)(5)
Am. Journal of Economics and Sociology	49(4)
American Journal of Epidemiology	132(4–6)
American Journal of Medicine	89(4–6)
American Journal of Orthopsychiatry	60(4)
American Journal of Psychiatry	147(9–12)
American Journal of Psychology	103(4)
American Journal of Sociology	96(3)
American Political Science Review	84(4)
American Psychologist	45(10–12)
American Sociological Review	55(5)(6)
Australian Journal of Psychology	42(1–3)
Australian and New Zealand Journal of Psychiatry	24(4)
Behavioral Medicine	16(4)
Behavioral Science	35(4)
British Journal of Cancer	62(4–6)
Canadian Medical Association Journal	143(7–12)
Child Welfare	69(5)(6)
Clinical Psychology Review	10(5)(6)
Cognitive Psychology	22(4)
Cognitive Therapy and Research	14(5)(6)
Community Mental Health Journal	26(5)(6)
Geriatrics	45(10–12)
Gerontologist	30(5)(6)
Health Education Quarterly	17(4)
Health Policy	76(1–3)
Health Psychology	9(5)(6)
Health Services Research	25(4)(5)
Health Values	14(5)(6)
Hispanic Journal of Behavioral Sciences	12(4)
Home Health Care Services Quarterly	11(3/4)
International Journal of Aging and Human Development	31(3)(4)
International Journal of Mental Health	19(4)
International Journal of Technology Assessment in Health Care	6(2–4)
Journal of Aging and Health	2(4)
Journal of Allied Health	19(3)(4)
Journal of Applied Behavioral Science	26(3)(4)
Journal of Applied Gerontology	9(4)
Journal of Applied Psychology	75(5)(6)
Journal of Behavioral Medicine	13(4–6)
Journal of Clinical Epidemiology	43(10–12)
Journal of Consulting and Clinical Psychology	58(5)(6)
Journal of Experimental Child Psychology	50(2–3)
Journal of Experimental Social Psychology	26(6)
Journal of Family Practice	31(4–6)
Journal of Nervous and Mental Diseases	178(10–12)
Journal of Pediatrics	117(46)
Journal of Policy Analysis and Management	9(4)
Journal of Policy Modeling	12(4)
Journal of Political Economy	98(5)(6)
Journal of Psychopathology and Behavioral Assessment	12(4)
Journal of Psychosocial Oncology	8(4)
Journal of Public Health Policy	11(4)
Journal of Rheumatology	17(10–12) (Suppl 20, 24, 25, 26)
Journal of School Health	60(8–9)(10)
Journal of School Psychology	28(4)
Journal of Social Issues	46(4)
Journal of Social Policy	19(4)
Journal of Social Psychology	130(4–6)
Journal of the American Medical Association	38(10–12)
Medical Care	29(12)(9s)(10–11)
Operations Research	38(5)(6)
Organization Studies	11(3)(4)
Perspectives in Biology and Medicine	34(1)
Policy Studies Journal	19(2)(3/4)
Policy Studies Review	9(4)
Psychological Medicine	20(4)
Psychological Record	40(3)(4)
Psychology and Aging	5(4)
Psychosocial Rehabilitation Journal	14(1)(2)
Psychosomatics	31(4)

Quality and Quantity	24(3)(4)
Quality Review Bulletin	16(1–2)
Review of Economics and Statistics	72(4)
Risk Analysis	10(4)
Scandinavian Journal of Psychology	31(4)
Social Forces	69(2)
Social Indicators Research	23(3)(4)
Social Problems	37(4)
Social Psychology Quarterly	53(4)
Social Science and Medicine	31(7–12)
Social Science Research	19(4)
Social Service Review	64(3)(4)
Socio-Economic Planning Sciences	24(4)
Sociology and Social Research	74(4)

Monographs, Government Documents, and Unpublished Reports

The unpublished reports cover work in progress and articles submitted for publication. Monographs, government publications, and unpublished reports cited in the annotations section have been received by the Clearinghouse during October through December 1990. Thus, it is possible for unpublished materials written prior to these months to appear in this issue.

This section lists citations to journal articles that have been classified under the medical subject heading (MEsh) "health status indicators" in the National Library of Medicine's MEDLARS system, specifically, in the SDILINE for October, November, or December 1990. Citations are printed with only slight modifications of format, in the order and form in which they appear in NLM's files.

Following NLM's convention, titles enclosed in brackets indicate that the article is published in a language other than English.

REFERENCE NUMBER 64
AU: Frattura L ; Tettamanti M; Spagnoli A
TI: **[An epidemiological study in basic medicine on the health status of the "very old:]**
SO: *Riv Inferm* 1990 Apr–Jun;9(2):70–5

A research protocol on the health and social situation of a sample of "very old" people seen in a setting of general practice. Besides its objective of defining the spectrum of problems presented by this group of patients, the investigation aims at evaluating the impact of an intervention which should include all the members of the care team (doctors, nurses, social and health assistants), to allow due attention also to the problems of relatives and of those who assure home assistance to the elderly.

REFERENCE NUMBER 65
AU: Bienstein C
TI: **[Introduction of a measuring instrument for the recording of respiratory endangerment and impairment in patients]**
SO: *Dtsch Krankenpflegez* 1989 Nov;42(11):741–5

REFERENCE NUMBER 66
AU: Hewson PH ; Humphries SM ; Roberton DM ; McNamara JM ;Robinson MJ
TI: **Markers of serious illness in infants under 6 months old presenting to a children's hospital.**
SO: *Arch Dis Child* 1990 Jul;65(7):750–6

Six hundred and eighty-two assessments were performed on 641 babies under 6 months of age who presented to the emergency department of the Royal Children's Hospital, Melbourne, to try and determine the best markers of serious illness in young infants. Detailed, specific questions that quantified a baby's functional response to illness gave the most useful information. As a group, the 6 most common predictive symptoms of serious illness were: taking less than half the normal amount of feed over the preceding 24 hours, breathing difficulty, having less than 4 wet nappies in the preceding 24 hours, decreased activity, drowsiness, and a history of being both pale and hot. The presence of the corresponding sign on examination increased the predictive value of the symptom by 10–20%. Specific, highly predictive (though less common) signs included moderate to severe chest wall recession, respiratory grunt, cold calves, and a tender abdomen. A list of low, medium, and high risk symptoms has been constructed and the 5 measurements that were most useful in predicting serious illness in young infants have been detailed.

REFERENCE NUMBER 67

AU: Schlaepfer-Pedrazzini L ; Infante-Castaneda C
TI: **[Health measurement: theoretical and methodologic perspectives]**
SO: *Salud Publica Mex* 1990 Mar–Apr;32(2):141–55

The present article consists of a revision of the different ways health has been measured and was ordered according to the historic evolution of the health concept and conditions. The development of health measures has paralleled the changes occurring in the epidemiologic profiles and the many refinements in the conceptualization and interpretation of health. Along the years, the meaning of health has become increasingly wider. Initially, only infectious diseases were considered; later, degenerative processes were included. Nowadays, health is viewed as multifactorial and as a reflection of the life style and conditions. This essay contains a description of the theoretical postulates upon which the different health measures are based, their strategies, and some of their limitations. It is divided into 5 main sections: morbidity, disability, and mortality indicators; measures of the health of the populations; sociomedical indicators, including measures of physical and mental health, as well as of the social component of health, positive health indicators, and, finally, a revision of measures of health need. It is of the utmost importance to be aware of the perspective used in the different public health research efforts since it has direct repercussions for the planning and evaluation of the health services and, in particular, for the quality of health care.

REFERENCE NUMBER 68

AU: van Weel C ; Meijboom-de Jong B ; van Weert H
TI: **[The patient's functional status; clinimetrics in family practice]**
SO: *Ned Tijdschr Geneeskd* 1990 May 26;134(21):1039–43

REFERENCE NUMBER 69

AU: Sidel VW ; Beizer JL ; Lisi-Fazio D ; Kleinmann K ; Wenston J ; Thomas C ; Kelman HR
TI: **Controlled study of the impact of educational home visits by pharmacists to high-risk older patients.**
SO: *J Community Health* 1990 Jun;15(3):163–74

Lack of information about medications coupled with high rates of utilization complicates compliance with medication regimens and increases the risk of adverse effects among older adults. We undertook a study of the efficacy of community-based interventions by pharmacists in a randomly allocated one-half of a sample of 284 older adults considered to be at high risk for medication-related problems. Information and attitudes towards prescription and over-the-counter medications did not differ significantly between the intervention and comparison groups, either before or after the pharmacist interventions. However, visits to physicians were significantly less in the intervention group, suggesting an important if unexpected impact on health-related behavior.

Address for reprint requests: Montefiore Medical Center, Albert Einstein College of Medicine, Bronx, NY 10467

REFERENCE NUMBER 70

AU: Fisher NM ; Pendergast DR ; Calkins EC
TI: **Maximal isometric torque of knee extension as a function of muscle length in subjects of advancing age.**
SO: *Arch Phys Med Rehabil* 1990 Sep;71(10):729–34

Many neuromuscular diseases are associated with muscle weakness. Assessment of this weakness by manual muscle testing or with hand-held equipment has been criticized. Furthermore, muscle length influences peak force development. One hundred fifty-three female and 116 male asymptomatic subjects between the ages of 20 and 80 (approximately 20 per decade) were studied. Maximal strength of the quadriceps group was determined isometrically, on a specially designed bench, at 3 hip angles (45 degrees, 90 degrees, and 180 degrees of extension), which represent 3 rectus femoris muscle lengths. Maximal strength was observed at a hip angle of 180 degrees and did not decrease significantly from 20 to 50 years of age, although the values for the male and female subjects over 50 years were significantly decreased (approximately 15% per decade). The increase in strength as the muscle was lengthened from 45 degrees to 180 degrees hip angle was about 80% (of the force at 45 degrees) in 20 year olds; strength decreased progressively with age to a value of approximately 50% in the 70 year olds. This greater reduction in maximal strength at longer quadriceps muscle lengths has functional significance in rising from a chair, climbing stairs, and eventually, walking and standing.

REFERENCE NUMBER 71

AU: Brooks WB ; Jordan JS ; Divine GW ; Smith KS ; Neelon FA
TI: **The impact of psychologic factors on measurement of functional status. Assessment of the sickness impact profile [see comments]**
SO: *Med Care* 1990 Sep;28(9):793–804

In this study the relationship between 4 psychologic health constructs (depression, anxiety, patient response bias, and hostility) and the Sickness Impact Profile (SIP) measurement of functional status was evaluated. The SIP, Carroll Depression Rating Scale (CDRS); and the Minnesota Multiphasic Personality Inventory (MMPI) were administered to 332 patients hospitalized for treatment of combined medical and psychiatric problems. Pearson's product-moment correlation was high between CDRS and SIP Total score ($r=0.67$) and between CDRS and SIP Psychosocial subscale ($r=0.72$); correlation was lower between CDRS and SIP Physical subscale ($r=0.44$). Six MMPI scales (depression, anxiety, psychasthenia, lie, K, hostility) correlated with SIP Total score ($r=0.18$ to 0.50), with SIP Psychosocial score ($r=0.28$ to 0.65) and less well with SIP Physical subscale ($r=0.07$ to 0.25). Factor analysis of the SIP categories showed 2 factors with eigenvalues greater than 1. Promax factor rotation showed all SIP Psychosocial categories and all measured psychologic variables loaded most heavily on factor 1. SIP Physical categories loaded most heavily on factor 2. Stepwise multiple regression analysis showed that psychologic variables account for 49% of the SIP total variance, 62% of SIP Psychosocial subscale variance, but only 19% of SIP Physical subscale variance. The CDRS accounts for the major portion of the explained variance with only minor additional contributions from the MMPI scales. We conclude that 1) the SIP discriminates psychosocial and physical dysfunction even in medical patients with extensive psychiatric comorbidity; 2) the SIP measures at least two dimensions of health, one of which is strongly related to depression; and 3) constructs measured by MMPI scales do not make a substantial independent contribution to SIP variance.

REFERENCE NUMBER 72
AU: Fielding JE
TI: **Worksite health promotion survey: smoking control activities.**
SO: *Prev Med* 1990 Jul;19(4):402–13

As part of the National Worksite Health Promotion Survey, a representative sample of worksites across the United States with 50 or more employees was asked about the presence and types of activities they sponsor to promote smoking control. Smoking control activities were reported at 35.6% (CI 32.6–38.6) of all worksites. Among worksites with any smoking control activity 76.5% (CI 71.7–81.3) had a formal policy restricting smoking, 54.3% (CI 48.7–59.9) provided information about the harmful effects of smoking, and 49.6% (CI 44.4–54.8) made self-help materials available. Individual counseling, group classes, workshops, follow-up support and reinforcement, or special events were available at 38.3% (CI 32.9–43.7) of worksites with any smoking control activities. Frequency increased as worksite size increased, with large frequency differences between the smallest and largest worksites. Smoking policies were most often put into effect to protect the health of nonsmokers (39.1%, CI 32.1–46.1) or to comply with regulations or laws (38.2%, CI 32.2–44.2). The most frequently reported benefit to the worksite of smoking control activities was improved employee health (35%, CI 26.2–43.8). Benefits were considered to outweigh the cost of activities at 36% (CI 29.6–42.4) of worksites, although 41.7%(CI 34.7–48.7) said it was too soon to gauge the relative size of costs and benefits.

REFERENCE NUMBER 73
AU: Geronimus AT ; Bound J
TI: **Black/white differences in women's reproductive-related health status: evidence from vital statistics.**
SO: *Demography* 1990 Aug;27(3):457–66

Maternal age-specific neonatal mortality risk differs by race, with the mid-20s risk low for whites but not blacks. This may be partially due to worsening health for black relative to white women. We analyzed deaths to young women in the aggregate and classified by causes that are also pregnancy risk factors. Over the predominant child-bearing ages, mortality increases for blacks exceeded those for whites, usually by at least 25%. These indicators that black/white health differences widen as women progress through young adulthood suggest that such discrepancies may play a role in the black/white infant mortality differential, which merits further research.

REFERENCE NUMBER 74
AU: Mauldon J
TI: **The effect of marital disruption on children's health.**
SO: *Demography* 1990 Aug;27(3):431–46

This study uses retrospective illness histories to investigate whether children's health deteriorates after parental separation. Separation is associated with illness in a multivariate cross-sectional analysis as well as in an analysis of a sample of disrupted children only, in which illness rates before and after separation are compared. Three explanations are hypothesized: (1) divorce reduces the resources available to children, (2) the stress of divorce depletes children's health, and (3) frailer children are selected into divorce. The first hypothesis has stronger support than the second, but the data are too poor for a rigorous test of either. The selection hypothesis is not supported.

REFERENCE NUMBER 75
AU: Frelick RW
TI: **Health in Kathmandu—spring 1989.**
SO: *Del Med J* 1990 Jun;62(6):1061–5

REFERENCE NUMBER 76
AU: Enderlein G
TI: **[Epidemiological analysis of rank category exposure effects using cumulative logistic models]**
SO: *Z Gesamte Hyg* 1990 Jul;36(7):390–2

Logistic regression is the fundamental procedure to analyze the dependence of the frequency of a binary disease indicator from exposure and other factors. Disease indicators with ranked levels contain a larger amount of information and permit a more precise prediction. For that, the cumulative logistic model was developed. Its application, demonstrated with an epidemiologic study for the dependence of arthritic changes in the knee-joint from intensity of kneeling stress and age, is very recommendable for the evaluation of well-designed epidemiologic studies concerning the prevalence of chronic diseases.

REFERENCE NUMBER 77
AU: Huda W ; Bews J
TI: **Population irradiation factors (PIFs) in diagnostic medical dosimetry.**
SO: *Health Phys* 1990 Sep;59(3):345–7

REFERENCE NUMBER 78
AU: Chakraborty AK
TI: **Utilization of health services [editorial]**
SO: *Indian J Public Health* 1989 Jan-Mar;33(1):3–4

REFERENCE NUMBER 79
AU: Ray R ; Nair A
TI: **Evaluation of care of the elderly in the Senior Citizens' Health Care Centre**
SO: *Ann Acad Med Singapore* 1990 May;19(3):315–25

In an effort to expand the community-based services for the elderly, the Senior Citizens' Health Care Centre (SCHCC) was developed in 1986, with the support of the Ministry of Health providing the policy direction and staff, and the Home Nursing Foundation bearing some of the operating expenditure. The first 171 clients with impaired physical functions who attended the center for day care and rehabilitation were studied. They were exposed to a program package inclusive of health and social areas. Specific areas covered were Activities of Daily Living (ADL), simple mental status examination, and use of mobility aids. The average duration of treatment at the center required by the 95 day care clients was 84 days or 20 visits, while the 76 rehabilitation clients required 71 days or 13 visits. The 68.4% of the clients who completed their treatment at the center successfully, reached the goals towards independence set for them well within 3 months of their admission into the center. This was noted when scores were compared at admission and discharge. Due to various reasons, 31.6% did not complete the treatment. This study shows how the elderly with physical impairments may benefit from the programs in the SCHCC.

REFERENCE NUMBER 80

AU: Bowman MA ; Sharp PC ; Herndon A ; Dignan MB
TI: **Methods for determining patient improvement following visits to family physicians.**
SO: *Fam Med* 1990 Jul-Aug;22(4):275–8

Two instruments were used to assess patient improvement following visits to providers in a university-based family practice center—the Modified Williamson Functional Assessment (MWFA) and the Mini-Duke-UNC Health Profile (Mini-DUHP). Of the 90 patients over the age of 18 seen for problem or health maintenance visits who were included in the study, 64 adequately completed the instruments at the time of the visit and one month later. Functional assessments by in-person, mail, and telephone methods of administration were similar. Patients' MWFA scores did not significantly improve by the time of the one-month follow-up. Mini-DUHP subscales for symptom and physical function also did not significantly improve. Mini-DUHP emotional, social, and composite scores indicated a decrease in function following the visits, particularly visits for health maintenance. MWFA and Mini-DUHP scores correlated only modestly, with the highest correlation occurring between Mini-DUHP Physical Score and the MWFA (0.414 or 0.509, P less than .001). Additional study is needed to identify or develop an instrument that can adequately assess broad changes in functioning for multiple diagnoses following specific physician interventions, and the reason for the decline in emotional and social function following visits needs further elucidation and evaluation.

REFERENCE NUMBER 81

AU: Tanaka K ; Matsuura Y ; Nakamura E ; Nakadomo F ; Kitao H ; Takeshima N ; Mimura K ; Maeda K
TI: **[Discriminant function analysis for evaluating the status of coronary heart disease risk]**
SO: *Ann Physiol Anthropol* 1990 Jan;9(1):59–65

We investigated to discriminate those individuals categorized by 1. obesity, 2. hypercholesterolemia, 3. hypertension, 4. low maximal oxygen uptake, 5. an abnormal electrocardiogram reflecting ischemic patterns, and/or 6. real sedentary life, from relatively healthier individuals without coronary heart disease (CHD) risk factors. One hundred and six Japanese women, aged 30 to 72 years, all of whom were in the postabsorptive state, were recruited in a series of tests for anthropometric and physiologic profiles both during the resting state and during the submaximal-maximal cycling exercise. Subjects were categorized into two groups—those who possessed 4 or more of the above 1, 2, 3, 4, 5, and 6 (high CHD-risk group, n = 15) and apparently healthy individuals with a minimum number of risk factors (low CHD-risk group, n = 83). Analyses of the data revealed that a combination of 8 variables extracted from among original 25 variables accurately classified 13/15 (87%) of the high CHD-risk group and 77/83 (93%) of low CHD-risk group (mean = 90/98 or 92%) into their respective groups. The 8 variables were double product, Katsura index, waist girth, chest girth, TG, TC, and skinfold thicknesses at the subscapular and abdominal sites. A subsequent t-test identified significant differences between groups not only for VO2max, SBP, and TC but also for DBP, LDLC, TG, Hb, HR, and HRmax. Most of these differences were of a much greater magnitude compared to the existing difference in chronological age. These findings suggest the usefulness and importance of anthropometric and blood lipid variables in the explanation of differences in the health status between high CHD-risk women and their counterparts.

REFERENCE NUMBER 82
TI: **Mortality analysis – some new uses for old indicators.**
SO: *Epidemiol Bull* 1989;10(2):1–6

REFERENCE NUMBER 83
AU: Varma JR
TI: **Skin tags – a marker for colon polyps?**
SO: *J Am Board Fam Pract* 1990 Jul-Sep;3(3):175–80

The frequency of colorectal cancer increased during the first half of the twentieth century, but for the last four decades, it appears to have stabilized. Today, the average American has a 5 percent probability of developing colorectal cancer during a 70-year life span. The majority of cases occur in persons aged greater than 50 years; the incidence increases up to age 75, after which there is a decline. Etiology is unknown; however, environment, genetics, and carcinogens have been implicated. Genetic relations of skin tags, colon polyps, and colon cancer are a matter of ongoing research. If such relations could be established, it could provide clinicians with a possible additional marker for persons at increased risk of colorectal adenoma and adenocarcinoma. Two cases are presented with a brief review of the literature.

REFERENCE NUMBER 84
AU: Netzle PA
TI: **[The dental findings in elderly retirement home pensioners]**
SO: *Schweiz Monatsschr Zahnmed* 1989;99(12):1373–80

General health, oral status, and personal oral hygiene of institutionalized and non-institutionalized elderly people were compared. Hospitalized patients revealed less favorable results. Of 202 residents of a nursing home (average age 81), most required daily assistance. More than half of these elderly were edentulous, one third were partially edentulous, and only 10% had almost a full complement of teeth. Sixty-percent of the edentulous had upper and lower complete dentures. Twenty-one percent of the partially edentulous had removable partial dentures. Dental hygiene was poor in most cases. In 60 patients, actual dental and prosthodontic treatment was modest when compared to treatment needs. Due to a compromised health status, aged patients often do not receive comprehensive oral rehabilitation. Therefore, professional dental hygiene and daily dental care must be incorporated into nursing home routines in order to prevent further tooth loss as a result of caries and periodontal disease.

REFERENCE NUMBER 85
AU: Robey JM ; Lee SH
TI: **Information system development in support of national health programme monitoring and evaluation: the case of the Philippines.**
SO: *World Health Stat* Q 1990;43(1):37–46

The Department of Health of the Philippines has recognized that data collection is an integral part of most, if not all, health service delivery elements of the primary health care approach. Indeed, considerable resources had already been invested in such activities. It had been estimated that up to 25% of local health workers' time was used to record and report data, usually to a higher level. Given that such a substantial proportion of a program's budget was invested in the data it collected, it was essential that the process should have some tangible benefit. The department has developed a policy and begun implementing an information-support capability aimed at improving the performance of its health programs at all levels of administration and management. The redesign process began with the Field Health Services Information System (FHSIS), which is responsible for the collection and dissemination of data regarding activities in all public-sector health facilities in the country, with the exception of those taking place on a hospital inpatient basis. This development places the Philippines in a leadership position among governments in overcoming the principal constraint in evaluating the progress towards achieving the goal of health for all by the year 2000, that constraint being inadequate information support to the managerial process.

REFERENCE NUMBER 86
AU: Hammoud EI ; Ouakrim M
TI: **Monitoring and evaluation of the health-for-all strategy: experience in the Eastern Mediterranean region.**
SO: *World Health Stat* Q 1990;43(1):32–6

This article is an account of the activities undertaken by the WHO Regional Office for the Eastern Mediterranean in relation to reporting on monitoring and evaluation of progress in the implementation of the strategy for health for all by the year 2000, and the resulting effect on improving coverage and the quality of data. Tables 1-3 compare the completeness of items in the Eastern Mediterranean Region's reports on the three cycles (1983, 1985, and 1988) to that for other regions and for the global level. The comparison is based on the respective global reports presented to the World Health Assembly.

REFERENCE NUMBER 87
AU: Nossikov A ; Prokhorskas R ; Shabanah M
TI: **Using regional indicators: the experience of Europe.**
SO: *World Health Stat* Q 1990;43(1):25–31

The 1987–1988 health-for-all (HFA) monitoring exercise produced a considerable amount of quantitative and non-quantitative data which were used for the assessment of the progress towards HFA in the European Region. At the same time it demonstrated many shortcomings and problems with regard to the availability and quality of data. Relevance of replies to non-quantitative indicators leaves considerable room for improvements. Good or satisfactory relevance can only be found in about one-third of the country replies. Data on most morbidity indicators, except infectious diseases, were provided on average by one-third of the countries. Nearly two-thirds of the countries provided data on cervical and breast cancer and some occupational diseases. At least half of the data seem not to be comparable; some data are potentially comparable, depending on additional information to be collected. Perceived health estimates are collected by a few countries, but data are not directly comparable. Many countries conduct surveys at different times on one or more aspects of lifestyle. However, comparable data are restricted mainly to educational levels, smoking, alcohol, and nutrients. Data on health services and resources are more promising, as they are provided by about two-thirds of the countries.

REFERENCE NUMBER 88
AU: Kalambay K
TI: **[Evaluation of regional indicators in Africa]**
SO: *World Health Stat* Q 1990;43(1):2–7

In view of the new demands created by primary health care, a group of experts met for the first time in 1980 to try to elaborate indicators appropriate to the African context which would help member states measure progress in primary health care. The new indicators were to be used in addition to the 12 global indicators proposed at Alma-Ata. In September 1985 at Lusaka, the Regional Director defined a 3-phase health development frame-work that would allow member states to set up primary health care methodically and progressively in three stages: at district and intermediate levels, and then centrally. In September 1988, a large-scale survey was conducted in the 44 member states of the region to test the validity of the indicators and to verify the feasibility of the method proposed for gathering and processing data. The surveys were conducted in households and were to involve local personnel and community participation. The indicators were to meet criteria such as simplicity, reproducibility, and validity, and were to approach health problems in a positive way, rather than in terms of failure quantified by mortality, morbidity, etc. Although the results of these surveys conducted in villages and urban areas cannot be extrapolated to the district or the country, they do give a faithful picture of the health situation in the districts where they were conducted. The study shows that the 27 indicators, suitably modified and adapted, are easily used at the community level, even by non-medical personnel.

REFERENCE NUMBER 89
AU: Wysocki MJ ; Krishnamurthi CR ; Orzeszyna S
TI: **Monitoring the progress of health-for-all strategies: the situation in South-East Asia.**
SO: *World Health Stat* Q 1990;43(1):16–24

Analysis of the results of the recent monitoring and evaluation of the HFA strategies of the 11 countries in WHO's South-East Asia Region shows that, in most cases, the process adopted for implementing the strategy has been the extension of coverage by health services operated by trained personnel. This process has not necessarily resulted in the equitable provision of health care, since it does not take into account the widely varying needs of different population groups within a country. For example, the infant mortality rate (IMR) for India was 96 per 1,000 live births (1986), but state-by-state analysis shows that the range by state is from 27 to 132. The figure for urban IMR at the national level is 62, compared to 105 for rural areas. Similarly, the IMR of 28.4 for Sri Lanka (1983) obscures extremes of variation between districts of 10.2–51.5. The health needs of disadvantaged areas or population groups can only be met in collecting and analyzsing data at lower levels than the national. This should not be difficult or expensive to achieve through suitable reorientation of peripheral and intermediate-level personnel. Improvements in the collection of data on some of the global indicators are documented by tables showing reported levels of coverage with maternal and child health care in 1983 (first monitoring), 1985 (first evaluation), and 1988 (second monitoring). Obtaining data on the birthweight of newborns appears to be difficult for some countries, and it is suggested that this indicator be replaced by one that asks whether the baby is healthy or not.

REFERENCE NUMBER 90
AU: Layne KA ; Losinski DS ; Zenner PM ; Ament JA
TI: **Using the Fleming index of dysphagia to establish prevalence.**
SO: *Dysphagia* 1989;4(1):39–42

The Fleming index of dysphagia was used to determine the prevalence of dysphagia in patients in a long-term, neuropsychiatric medical center. Prevalence varied by section, with the ventilator-dependent patients having the highest rate and the chemical-dependent patients having the lowest. The Fleming index appears to be a quick and useful instrument to identify patients who are at risk of dysphagic complications, but further reliability and validity studies are needed to demonstrate its utility.

REFERENCE NUMBER 91
AU: Jenkinson C ; Fitzpatrick R
TI: **Measurement of health status in patients with chronic illness: comparison of the Nottingham health profile and the general health questionnaire.**
SO: *Fam Pract* 1990 Jun;7(2):121–4

The results of two commonly used instruments for measuring health status were compared in patients with chronic illness. The Nottingham health profile (NHP) is a measure of perceived health, while the general health questionnaire (GHQ) is a measure of non-psychotic psychiatric disturbance. The questionnaires were completed by patients suffering either rheumatoid arthritis or migraine. The results provide evidence that, despite some specific problems in the measurement of pain and emotional reactions, the NHP and GHQ may be used to assess the impact of illness upon sufferers' lives, not only in severely disabling disorders such as rheumatoid arthritis, but in health problems such as migraine which have often been considered as relatively minor ailments.

REFERENCE NUMBER 92
AU: Goff GM
TI: **Cabarrus County employees "Leap into Life" program [news]**
SO: *Am J Public Health* 1990 Aug;80(8):998–9

REFERENCE NUMBER 93
AU: Pletsch PK
TI: **Hispanics: at risk for adolescent pregnancy?**
SO: *Public Health Nurs* 1990 Jun;7(2):105–10

Data from the Hispanic Health and Nutrition Examination Survey, 1982-1984, were analyzed to describe pregnancy, miscarriage, and age-specific birth rates as well as oral contraceptive use among Mexican-American, Puerto Rican, and Cuban-American females age 12 to 19 years. The Cuban-American sample (n = 85) had the lowest pregnancy (99) and fertility (37) rates, with 6.5% ever having used oral contraceptives. In the Mexican-American (n = 638) and Puerto Rican women (n = 300) the pregnancy and fertility rates were 205 and 223, and 141 and 110, respectively. Of these two groups, 14.5% and 12.6% had ever used oral contraceptives. These results suggest that Mexican-Americans and Puerto Ricans are at risk for adolescent pregnancy, with the latter having more of the sociodemographic characteristics associated with the long-term disadvantages of early childbearing. These facts have implications for nursing practice and research.

REFERENCE NUMBER 94
AU: Liang MH ; Fossel AH ; Larson MG
TI: **Comparisons of five health status instruments for orthopedic evaluation.**
SO: *Med Care* 1990 Jul;28(7):632–42

This study represents a long-term effort to find optimal techniques for evaluating outcome in patients who have undergone total joint arthroplasty. Sensitivity of 5 health status questionnaires was studied in a longitudinal evaluation of orthopedic surgery. The questionnaires (Arthritis Impact Measurement Scales [AIMS], Functional Status Index [FSI], Health Assessment Questionnaire [HAQ], Index of Well-Being [IWB], and Sicknes Impact Profile [SIP]) were administered to 38 patients with end-stage arthritis at 3 points in time: 2 weeks before hip or knee arthroplasty, and at 3-month and 12- to 15-month follow-up. Response values (i.e., changes within patients) were calculated on 4 scales: global health, pain, mobility, and social function. By the 3-month follow-up, most instruments detected large mean responses in global health, pain scores, and mobility. Smaller changes on these scales were found between 3 and 12 to 15 months. Social function showed small to modest gains at successive follow-ups. Standardized response means were calculated to assess sensitivity to detect change. Confidence intervals for these indices were constructed using a jackknife procedure, and significance tests were performed by pairing selected indices. Finally, the study projected sample sizes required to assess a new therapy, using each response. These statistical tools facilitated comparisons among instruments and may prove useful in other settings.

REFERENCE NUMBER 95

AU: Pilpel D ; Schneiderman K ; Galinsky D
TI: **Gross intellectual impairment among non-institutionalized elderly: difficulties in assessment and risk factors.**
SO: *J Community Health* 1990 Jun;15(3):209–23

Quality of life of both the aged person and his relatives depends, to a large extent, on the capacity of the old person to think and to remember. In an attempt to assess the intellectual capabilities (InC) of the elderly and to identify risk factors associated with intellectual impairment (InI), a community study was carried out. The study population was ethnically heterogeneous and comprised of a high percentage of immigrants and of people who had never attended school. Some methodological issues related to studying InC of a population with these characteristics are discussed. A stratified random sample of non-institutionalized individuals aged 65+ years was home interviewed using a short, portable questionnaire which can be used by non-professional interviewers. The research tool is composed of 10 questions which check time and place orientation as well as short- and long- term memory. Although the validity of the questionnaire needs further study, some conclusions can be drawn. Approximately 16% of the subjects failed to answer correctly at least 5 of the 10 questions. People over 75 years old, single persons, those with low education and low environmental stimulation were identified as high-risk groups for InI, as defined in our study. Functional limitation, such as immobility, dependence in daily functions and hearing deprivation seem to affect the InC of the aged, especially of the less-educated people. Such findings may suggest the need to plan community-oriented prevention programs for the sake of the growing population of the aged in western countries.

REFERENCE NUMBER 96

AU: Auslander WF ; Anderson BJ ; Bubb J ; Jung KC ; Santiago JV
TI: **Risk factors to health in diabetic children: a prospective study from diagnosis.**
SO: *Health Soc Work* 1990 May;15(2):133–42

This study explored associations between health status and psychosocial, family, and demographic factors among 42 children with recently diagnosed diabetes mellitus. Health status was assessed using glycosylated hemoglobin (HbA1), a measure of the children's level of metabolic control. Four groups of variables were investigated as possibly relating to metabolic control: demographics, family social climate, child's self-concept, and compliance with the treatment regimen. Metabolic control was associated with race, number of parents in the home, family cohesion, and socioeconomic status. Multiple regression analysis indicated that children from black and single-parent families were at higher risk for poorer disease control and that this pattern persisted 2 and 3 years after diagnosis. These findings can help identify families that may benefit from more effective interventions involving social work practice.

REFERENCE NUMBER 97
AU: Mulcahy R ; Bacon M ; Conroy R
TI: **The health and risk factor status of industrial employees.**
SO: *Ir Med J* 1990 Mar;83(1):8–10

Employees from 13 Irish industries (2,183) volunteered to take part in a risk-factor identification and health counselling program. Data are presented about the risk-factor profile of the group. Alcohol abuse, overweight and hyperlipidaemia were prevalent, particularly among men. Hypertension, although relatively infrequent, was more common among men and, like hyperlipidaemia and obesity, increased significantly with age. The subjects who smoked cigarettes accounted for 33% of the population studied, while 21% were ex-smokers, with substantially more ex-smokers among men than women. Only 22% of subjects took adequate exercise. Work stress was unusual but personal stress common. Only 75% of subjects used their seat belts regularly and the majority received no regular dental care. The role of industrial health programs in disease prevention and health education, and in providing benefit to industry, is examined. Recommendations are made about effective means of encouraging healthy living in an industrial environment.

REFERENCE NUMBER 98
AU: Carmen E ; Brady SM
TI: **AIDS risk and prevention for the chronic mentally ill.**
SO: *Hosp Community Psychiatry* 1990 Jun;41(6):652–7

Some chronic mentally ill populations are at high risk for infection with human immunodeficiency virus. The authors argue that stereotypes of the mentally ill as asexual or neutered have had dangerous consequences, namely the absence of sex education and AIDS prevention as an integral part of treatment. To counter this neglect, the authors developed an AIDS prevention program in a large inner-city mental health center that serves primarily black and Latino patients. Prevention efforts include individual risk assessments and an innovative drop-in group. Central to effective patient education are the distribution of condoms and concrete instruction in their use.

REFERENCE NUMBER 99
AU: Cousineau D
TI: **[Global health index among immigrants in Quebec]**
SO: *Can J Public Health* 1990 May-Jun;81(3):187–90

Ridit, a global health index, was analyzed in 2,461 immigrants established in the province of Quebec and this value was compared with that obtained in 25,171 natives of Quebec. Ridit values were not significantly different between immigrants and native Quebecers, suggesting a comparable global health status in both groups. Among immigrants, women had a poorer global health index than men, a phenomenon identical to that previously observed in native Quebecers. Immigrants established since 1980 (25% of all immigrants) had a better global health index than native Quebecers, while immigrants established before 1980 were not significantly different. Immigrants represent several ethnic groups for which a global health index could not be defined.

REFERENCE NUMBER 100

AU: Weisensee M ; Anderson JM ; Lapp CA

TI: **Implementation of a self-health project by baccalaureate students.**

SO: *Nurs Forum* 1989;24(3–4):3–8

With increasing evidence that life-style is an important influence on health, 3 nursing faculty members at the University of Minnesota implemented a learning project to enable students to assess, plan, and evaluate their own life-styles. The goal was to have the students attempt to make positive changes. As part of a "health concepts" nursing course, students became much more aware of social, economic, environmental, and cultural factors that either enhanced or detracted from their ability to achieve their ideal life-styles. The students responded favorably to this assignment because of the potential benefits of investing in themselves while pursuing the rigorous program leading to a nursing degree.

REFERENCE NUMBER 101

AU: Dutkowsky JP ; Shearer D ; Schepps B ; Orton C ; Scola F

TI: **Radiation exposure to patients receiving routine scoliosis radiography measured at depth in an anthropomorphic phantom.**

SO: *J Pediatr Orthop* 1990 Jul-Aug;10(4):532–4

Concern about the amount of radiation received during scoliosis evaluation and treatment led us to measure radiation exposure in an anthropomorphic phantom to determine the increased risk of breast cancer in young women with scoliosis. Assuming that 22 radiographic examinations were performed over the course of scoliosis treatment, the increased relative risk of breast cancer was determined to be 0.22% in these patients.

Why "Indexes"?

In the health field the terms "index" and "indicator" have been used interchangeably when the primary measure of health status was a single measure such as a mortality rate or life expectancy. More recently, however, research efforts have focused on developing composite measures that reflect the positive side of health as well as changing disease and death patterns. Progress is being made, and the resultant health status measures are being applied. Although the measures have become more complex, the terms "index" and "indicator" are still used interchangeably. In providing information to assist in the development of composite health measures, the Clearinghouse has adopted the following definition: a health index is a measure which summarizes data from two or more components and which purports to reflect the health status of an individual or defined group.

Why a "Clearinghouse"?

It has become apparent that different health indexes will be necessary for different purposes; a single GNP-type index is impractical and unrealistic. Public interest coupled with increased government financing of health care has brought new urgency for health indexes. Their development can be hastened through active communications; the Clearinghouse was established to provide a channel for these communications.

What's Included?

The selection of documents for the Clearinghouse focuses on efforts to develop and/or apply composite measures of health status. A reprint or photocopy of each selection is kept on file in the Clearinghouse. Domestic and foreign sources of information will include the following types of published and unpublished literature: articles from regularly published journals; books, conference proceedings, government publications, and other documents with limited circulation; speeches and unpublished reports of recent developments; and reports on grants and contracts for current research. The Clearinghouse will systematically search current literature and indexes of literature to maintain an up-to-date file of documents and retrospectively search to trace the development of health indexes. Specifically, items will be included if they

1. advance the concepts and definitions of health status by
   a) operationalizing the definition
   b) deriving an algorithm for assigning weights
   c) computing transitional probabilities
   d) validating new measures

2. use composite measure(s) for the purpose of
   a) describing or comparing the health status of two or more groups
   b) evaluating a health care delivery program

3. involve policy implications for health indexes

4. review the state of the art

5. discuss a measure termed "health index" by the author

What Services?

The Clearinghouse publishes the *Bibliography on Health Indexes* four times each year. This compilation consists of citations of recent reprints or photocopies included in the Clearinghouse file of documents. Each citation in the ANNOTATIONS Section will be followed by a brief summary of the article. The period covered and the sources used in the compilation will be clearly stated in each issue. At present, the Bibliography, its abstracts, and other notes are all printed in English. Also presented in the Bibliography is information about forthcoming conferences, notification of publication of previously cited forthcoming materials, new information sources, etc. Addresses of contributors and sponsoring organizations for conferences are given in each Bibliography. Readers should contact the authors directly to request reprints or to discuss particular issues in greater detail. To obtain additional information about purchasing the *Bibliography on Health Indexes* on a regular basis, write to the following address:

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