

# Family physicians' approach to psychotherapy and counseling

## *Perceptions and practices*

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### SUMMARY

To determine how family physicians perceive the support they get for psychotherapy and counseling, we surveyed a random sample of Ontario College of Family Physicians members. Of 100 physicians who had family medicine residency training with psychotherapy experience, 43% indicated that such training was inadequate for their current needs. Because family physicians often provide psychotherapy and counseling, their training should reflect the needs found in practice.

### RÉSUMÉ

Afin de déterminer comment les médecins de famille perçoivent le soutien qu'ils ont reçu dans les domaines de la psychothérapie et du counselling, nous avons effectué une enquête auprès d'un échantillon aléatoire de membres du Collège des médecins de famille de l'Ontario. Parmi les 100 médecins formés dans un programme de résidence en médecine familiale offrant une expérience en psychothérapie, 43% ont indiqué que cette formation était inadéquate pour répondre à leurs besoins actuels. Puisque les médecins de famille sont souvent appelés à dispenser des soins de psychothérapie et de counselling, leur formation devrait refléter les besoins de la pratique.

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**F**AMILY PRACTITIONERS OFTEN support patients and their families through emotional and physical illness with empathy, understanding, and careful advice. Data from the Ontario Health Insurance Plan (OHIP) indicate that family physicians billed the plan for 96% of the psychotherapy (*Table 1*) and 91% of the counseling performed in 1981 and 1982. Reports from OHIP show that the amounts billed for therapy and counseling have increased in subsequent years (personal communication from E. Murray). Heseltine<sup>1</sup> reports that 80% to 90% of psychiatric cases are managed by family physicians alone without psychiatric consultation and postulates that OHIP figures underestimate the time spent in therapy.

Family medicine residency programs have tried to enhance the psychotherapy training for medical graduates to better prepare them for the demands of practice. However, not all family physicians have been involved with residency programs.

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This paper reports the results of a survey designed to determine whether family physicians think they receive enough support from their training programs, the OHIP fee schedule, and their colleagues in psychiatry.

### METHODS

The survey instrument was a 28-item questionnaire that collected demographic data and asked about views on the use of counseling and psychotherapy in practice. It was pre-tested on members of the Board of Directors of the Ontario College of Family Physicians and on family physicians in Burlington, Ont. A modified version of the questionnaire was then sent to 305 members of the College who were randomly selected by computer from the membership list. A second mailing was sent 3 weeks later to those who had not responded. Data were tabulated and analyzed on the Statistical Package for the Social Sciences (SPSS) program at the Ontario Institute of Studies in Education in Toronto and on STATISTIX 3.1 (Analytical Software, St Paul, Minn). Where dichotomous groups were discovered, their characteristics were compared by the continuity-corrected  $\chi^2$  method. No

attempt was made to validate the reported information with actual practice patterns.

## RESULTS

### Sample description

We mailed 305 questionnaires; 201 (65.9%) were returned after two mailings; 198 responses could be used. Of the

certification status. *Table 2* divides respondents by the number of half-hour sessions of psychotherapy and counseling done each week. Most physicians performed one to five sessions of psychotherapy and counseling each week. Not included in this table are sessions that did not last a full 20 minutes; they cannot be billed to OHIP as psychotherapy or counseling. Such sessions were performed at least once each week by 135 (68.5%) and 125 (63.1%) respondents for psychotherapy and counseling, respectively. Sixty-one (30.8%) and 55 (27.7%) respondents performed psychotherapy and counseling, respectively, more than 10 times each week in sessions lasting less than 20 minutes. A great variety of techniques were used for psychotherapy (*Table 3*); supportive psychotherapy was used most frequently.

Although 63 (31.8%) respondents thought that neither counseling nor psychotherapy was precluded in practice, 110 (55.6%) thought that the demands of other parts of practice interfered with their ability to do psychotherapy (*Table 4*).

### Perceived needs of patients

The percentages of patients per practice who were perceived to have problems that required psychotherapy or counseling are presented in *Table 5*. Fifty-eight physicians (29.2%) perceived that more than 30% of their patients had problems that required psychotherapeutic intervention; 65 (32.8%) indicated that more than 30% of their patients had problems requiring counseling.

In general, those respondents who perceived more of their patients as needing psychotherapy reported doing more psychotherapy ( $P = 0.001$ ). Yet some respondents, who identified that more than 50% of their patients needed psychotherapeutic intervention, did five or fewer sessions per week.

### Psychotherapy training

Of the 100 family practice residency graduates, 42 (42.0%) reported that they had had psychotherapy training in their residencies that met their current practice needs; 43 (43.0%) indicated that, although they had had psychotherapy training in their residencies, it was inadequate for their current requirements. Nine residency

**Table 1. Definitions according to the Ontario Health Insurance Plan**

**Psychotherapy:** Any form of treatment for mental illness, behavioural maladaptations, or other problems that are assumed to be of an emotional nature, in which a physician deliberately establishes a professional relationship with a patient for the purposes of removing, modifying, or retarding existing symptoms, or attenuating or reversing disturbed patterns of behaviour and of promoting positive personality growth and development is psychotherapy. The minimum period for psychotherapy (to be claimed as such) is 20 minutes.

**Counseling:** Counseling is distinct from psychotherapy and is that form of activity in which the physician engages in an educational dialogue with the patient, on an individual or group basis, where in the goal of the physician and patient is to become aware of the patient's problems or situation and of modalities for prevention or treatment. If the counseling session is less than 20 minutes, the appropriate assessment fee should be claimed.

respondents, 44 (22.2%) were women, 139 (70.2%) were certificated, and 100 (50.5%) were residency trained. One hundred forty-seven (74.2%) were graduates of Ontario medical schools; 17 (8.5%) were trained at other Canadian universities; 18 (9.0%) were trained in the United Kingdom; and 16 (8.0%) were trained in other countries. Respondents' years of graduation ranged from 1928 to 1983, and their ages ranged from 24 to 79 years.

It was statistically significant that more respondents than nonrespondents were certificated ( $P = 0.003$ ), but the groups were comparable in male to female ratio. The geographic distribution by postal code among respondents and nonrespondents was similar.

### Amount and type of therapy

The amount of psychotherapy being done was unrelated to sex, residency training, or

graduates (9.0%) denied any psychotherapy training in residency, and six (6.0%) reported training but did not respond regarding its adequacy.

Seventy (75.2% of the 93 who answered the question) family practice residency program graduates had not been involved in any psychotherapy training beyond their residency. Twenty-three (24.7%) had undertaken psychotherapy training beyond residency. Twenty-seven (30.6%) respondents who were not family practice residency graduates had taken further psychotherapy training and 61 (69.3%) had not.

Of the 42 graduates of residency programs who thought that their psychotherapy training had been adequate for their current needs, five (11.9%) had done further training. But 15 (34.9%) of the 43 who thought that they had received inadequate training had done further training ( $P = 0.02$ ).

#### Availability of psychiatric backup

Of the whole sample, 33 (16.6%) had no psychiatrists available in their community, 69 (34.8%) had one to five psychiatrists available, 16 (8.0%) had five to 10, and 79 (39.9%) had more than 10 psychiatrists available. For an acute psychiatric problem, a consultation was available within 24 hours for 147 (74.2%), after 2 days for 21 (10.6%), and after more than 2 days for 27 (13.6%). Consultation for a chronic problem was available after more than 2 days but within 2 weeks for 77 (38.9%), and after more than 2 weeks but within 2 months for 107 (54.0%) respondents.

Other referral services that were used included (in descending order of frequency): patient-paid psychologists, agency-paid psychologists, patient-paid social workers, agency-paid social workers, sociologists, clergy, community health centres, public health nurses, and hospital-based services. Although relative frequencies were recorded, the actual frequency of using these services was not determined.

## DISCUSSION

### Training programs

Family practice residency programs need to evaluate more closely the requirements of physicians in practice and to assess how well they train residents in psychotherapy and counseling. This survey found that only 42% of family physicians who had had a residency training program thought that the training was adequate for their

Table 2. Number of half-hour sessions per week of psychotherapy or counseling

NO. OF SESSIONS PER WEEK	NO. OF RESPONDENTS N = 198	
	PSYCHOTHERAPY (%)	COUNSELING (%)
0	16 (8)	18 (9)
1-5	117 (59)	114 (58)
6-10	43 (22)	45 (23)
11-15	8 (4)	8 (4)
16-20	7 (4)	4 (2)
No response	7 (4)	9 (5)

Table 3. Reported frequency of various therapeutic techniques

TYPE OF THERAPY	NEVER (%)	INFREQUENTLY (%)	OCCASIONALLY (%)	FREQUENTLY (%)	NO RESPONSE (%)
Formal psychotherapy	57.1	8.5	5.6	5.6	23.3
Transactional analysis	42.9	20.2	9.6	6.1	21.2
Hypnotherapy	58.6	8.1	6.6	3.6	23.4
Relaxation therapy	25.3	20.7	27.3	8.1	18.7
Balint groups	54.0	3.5	6.1	5.1	31.3
Neurolinguistics	61.6	6.1	1.5	0.5	30.3
Supportive psychotherapy	3.0	5.1	13.1	71.7	7.1

needs in practice. Residents' perceptions of training adequacy have been reported in other studies. Brown and Weston<sup>2</sup> reported a survey of family medicine graduates from the residency program at

**Table 4. Reasons for not doing psychotherapy or counseling (respondents could indicate more than one reason)**

REASON	NO OF RESPONDENTS N = 198	
	PSYCHOTHERAPY	COUNSELING
No reason	63	63
Inflexible slots	49	57
Inadequate fees	41	39
Lack of training	50	21
Demands of practice	110	96
Other	5	6

the University of Western Ontario. All respondents were providing supportive psychotherapy, yet fewer than 50% of the residents felt satisfied with their psychosocial skills. Brown and Weston suggested that recent graduates feel inadequate in dealing "with the varied organic problems common in family medicine but uncommon in their experience as medical students." They add, "Perhaps only after they feel comfortable with their basic medical skills are they secure enough to tackle patients' personal problems."

It would be interesting to compare recent graduates' perceptions of the training they have received in treating organic and psychosocial problems. Has enhanced training in psychotherapy made any difference? Those who believed themselves least adequately trained would intuitively be expected to have sought the most postresidency training.

The most common therapy provided by respondents was supportive psychotherapy. Family physicians treat traditional psychiatric problems, such as depression, psychosis, generalized anxiety disorder, and personality disorder, as well as more common problems, such as unemployment, grief, insomnia, drug abuse, violence, anxiety, chronic illness, life-threatening situations, and chronic pain. Formal psychotherapy is not required for many of these problems, but

hours are spent helping patients deal with them. Whether these issues present as part of a physical symptom complex or are identified as problems in themselves, family physicians must be able to recognize and deal with them initially and often must provide ongoing therapy. Supportive psychotherapy is an important aspect of treating the whole person. Feightner and Worrall<sup>3</sup> in their review of depression, reported that 50% of patients with nonpsychologic complaints who met the standard clinical criteria of depression were not recognized as being depressed. Ford<sup>4</sup> reported similar findings

#### **The OHIP fee schedule**

Data from OHIP cannot be used to determine the amount of psychotherapy and counseling family physicians provide. Sixty-one (31%) respondents reported that more than 10 sessions each week were mainly psychotherapeutic but could not be billed to OHIP as such because they did not last for the required 20 minutes. Similarly, counseling was frequently billed as other than "counseling" by the OHIP definition because less than 20 minutes were spent in therapy.

Sessions that last 5 to 30 minutes have been reported effective for helping patients become symptom free.<sup>5</sup> Collyer<sup>6</sup> calculated the mean time spent in psychotherapy as 18.4 minutes. The 20-minute rule is an arbitrary marker for billing purposes. The inflexibility of 20-minute billing slots was the second most common reason given for not spending time in psychotherapy (Table 4). Some physicians dealt with the problems imposed by time-limited billing definitions with other billing strategies. Low fees as a limiting factor was noted by 41 (20.7%) respondents.

#### **Support from psychiatrist colleagues**

When support of a psychiatrist was necessary, 75% of the respondents were able to arrange an acute psychiatric consultation within 24 hours. Chronic problems were less well supported. More than 50% had to wait for up to 2 months for help with a chronic problem. (This survey did not ask whether the waiting period for a consultation for a chronic problem was considered appropriate.) In

the meantime, family physicians had to deal with these psychiatric illnesses. Fortunately, other services are often available to help family physicians who are beyond their capabilities in training or time.

Emotional and psychiatric illnesses make up a large part of the patient problems seen in practice. Collyer,<sup>6</sup> in reviewing his practice, found that he spent 30% of his office time in formal psychotherapy and approximately half of his time dealing with emotional illnesses. Fisher,<sup>7</sup> in his review article, states that 18% of visits involve counseling or psychotherapy. Commonly, 20% to 25% of patients attending primary care facilities have emotional factors contributing to their illness.<sup>8-10</sup> This survey reported perceived needs for psychotherapy or counseling that are consistent with the prevalence of psychosocial problems found elsewhere. Similarly, the amount of psychotherapy being done was comparable to what others have found.<sup>11,12</sup>

"Demands of other parts of practice" was the most frequently cited factor for not doing psychotherapy. This might indicate that the physicians surveyed consider organic illness a greater priority than psychosocial problems, or that they prefer dealing with the less emotionally taxing organic illnesses. Lack of training was also listed as a common reason for not performing counseling or psychotherapy. (Lack of training in psychotherapy was considered a problem by more physicians than lack of training in counseling.) Residency training programs should change this perspective by providing

training that gives family physicians greater comfort and facility in dealing with this important part of patient care.

The survey was one of self-reported work experience, and therefore is subject to the "obsequiousness bias"<sup>13</sup> where respondents overestimate "good" characteristics and underreport "undesirable" characteristics. As this was a survey about psychotherapy and counseling, respondents might overreport the therapy they perform and the patient need that they perceive. Battista<sup>14</sup> reported a 10% overestimate of what preventive procedures physicians reported compared with the number of procedures they did, measured by billings to the insurance plan.

## CONCLUSION

The results of this survey suggest further questions. What are the needs of practising physicians for training in counseling and psychotherapy? How are they best taught? What are the characteristics of those residency-trained physicians who believed they were adequately trained?

Family physicians are important providers of emotional and psychotherapeutic support to patients. They need to be encouraged to continue their efforts to treat patients as whole people, and not to ignore the person for the illness. ■

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**Table 5. Family physicians' perceptions of the proportion of their patients that require psychotherapy or counseling**

NO. OF RESPONDENTS N = 198		
PATIENTS (%)	PSYCHOTHERAPY (%)	COUNSELING (%)
<10	39 (19.6)	30 (15.1)
10-30	97 (48.9)	95 (47.9)
30-50	49 (24.7)	45 (22.7)
>50	9 (4.5)	20 (10.1)
No response	4 (2.0)	8 (4.0)

## CECLOR cefaclor

**THERAPEUTIC CLASSIFICATION:** Antibiotic. **MICROBIOLOGY:** The bactericidal action of CECLOR results from the inhibition of cell-wall synthesis. CECLOR is active in vitro against most strains of clinical isolates of the following organisms: *Staphylococci*, including coagulase-positive, coagulase-negative, and penicillinase-producing strains (when tested by *in vitro* methods), exhibit cross-resistance between cefaclor and methicillin; *Streptococcus pyogenes* (group A  $\beta$ -hemolytic streptococci); *Streptococcus pneumoniae*; *Moraxella catarrhalis* (formerly *Branhamella catarrhalis*) including  $\beta$ -lactamase positive and negative strains; *Haemophilus influenzae*, including  $\beta$ -lactamase-producing ampicillin-resistant strains; *Escherichia coli*; *Proteus mirabilis*; *Klebsiella sp.*; *Neisseria gonorrhoeae*; *Bacteroides sp.*; *Peptococci*; *Peptostreptococci*. **INDICATIONS AND CLINICAL USES:** CECLOR may be used in the treatment of the following infections caused by *Streptococcus pyogenes* and *Streptococcus pneumoniae*, *Staphylococci*, including coagulase-positive, coagulase-negative, and penicillinase-producing strains, *Escherichia coli*, *Proteus mirabilis*, *Klebsiella pneumoniae*, *Haemophilus influenzae*, including ampicillin-resistant strains: 1. Otitis media, 2. Lower Respiratory Tract Infections, including pneumonia, bronchitis, and pulmonary complications resulting from cystic fibrosis, 3. Upper Respiratory Tract Infections, including pharyngitis and tonsillitis, 4. Skin and Soft-Tissue Infections, 5. Urinary Tract Infections. Appropriate culture and susceptibility studies should be performed. **CONTRAINDICATIONS:** CECLOR is contraindicated in persons who have shown hypersensitivity to the cephalosporin antibiotics. **WARNINGS:** BEFORE THERAPY WITH CECLOR (CEFACTOR) IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEFACTOR, CEPHALOSPORINS, PENICILLINS OR OTHER DRUGS. IF THIS PRODUCT IS TO BE GIVEN TO PENICILLIN-SENSITIVE PATIENTS, CAUTION SHOULD BE EXERCISED BECAUSE CROSS-HYPERSENSITIVITY, INCLUDING ANAPHYLAXIS, AMONG  $\beta$ -LACTAM ANTIBIOTICS HAS BEEN CLEARLY DOCUMENTED. Antibiotics including CECLOR should be administered with caution, and then only when absolutely necessary, to any patient who has demonstrated some form of allergy, particularly to drugs. As is the case with all new drugs, patients should be followed carefully so that adverse reactions or unusual manifestations of drug idiosyncrasy may be detected. If an allergic reaction to CECLOR occurs, the drug should be discontinued and the patient treated with the usual agents (e.g., epinephrine, antihistamines, pressor amines or corticosteroids). Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics; therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening. Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out. **PRECAUTIONS:** If an allergic reaction to CECLOR occurs, the drug should be discontinued and the patient treated appropriately. The safety of cefaclor in the treatment of infections during pregnancy has not been established. Small amounts of CECLOR, up to 0.21 mg/L, have been detected in mother's milk following administration of single 500 mg doses. The effect on nursing infants is not known. Caution should be exercised when CECLOR is administered to a nursing woman. Prolonged use of cefaclor may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, administration of CECLOR should cease and appropriate measures should be taken. Positive direct Coombs' tests have been reported during treatment with cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures, when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug. CECLOR should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage is likely to be lower than that usually recommended. In patients treated with CECLOR, a false-positive reaction for glucose in the urine may occur with Benedict's or Fehling's solution or with Clinistest tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP). There have been rare reports of increased prothrombin time with or without clinical bleeding in patients receiving CECLOR and warfarin concomitantly. **ADVERSE REACTIONS:** During clinical trials in 8,346 patients, the following adverse reactions or abnormal laboratory values were observed with CECLOR. **Gastrointestinal** - The most frequent side effect has been diarrhea (1 in 70; 1.4% patients). It was rarely severe enough to warrant cessation of therapy. Nausea, 0.6% and vomiting; 0.4% have been reported. As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported. Colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with or after therapy with CECLOR has stopped. **Hypersensitivity** - Allergic reactions, such as urticaria and morbilliform eruptions, have been observed, as have pruritis and positive Coombs' tests. These reactions usually subsided upon discontinuation of the drug. Eosinophilia (1 in 50; 2% patients), genital pruritis or vaginitis (less than 1 in 100 patients), and rarely, thrombocytopenia or reversible interstitial nephritis have also occurred. Cases of serum sickness-like reactions have been reported. In contrast to classic serum sickness, signs and symptoms of serum, sickness-like reactions involving CECLOR appear to be primarily confined to findings including erythema multiforme or other skin manifestations accompanied by arthritis/arthralgia, with or without fever. Serum sickness-like reactions are apparently due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with CECLOR. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.05%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = 2 to 3 days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported. More severe hypersensitivity reactions, including Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy. **Central Nervous System** - Rarely reversible hyperactivity, nervousness, insomnia, confusion, hypotonia, dizziness, or somnolence have been reported. **Other** - Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed here to serve as alerting information for the physician. **Hepatic** - Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40; 2.5%). **Hematopoietic** - Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia, aplastic anemia, agranulocytosis and reversible neutropenia of possible clinical significance. There have been rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Cefaclor and warfarin concomitantly. **Renal** - Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). **SYMPTOMS AND TREATMENT OF OVERDOSAGE:** Signs and Symptoms - The toxic symptoms following an overdose of cefaclor may include nausea, vomiting, epigastric distress, and diarrhea. The severity of the epigastric distress and the diarrhea are dose related. If other symptoms are present, it is probable that they are secondary to an underlying disease state, an allergic reaction, or the effects of other intoxication. **Treatment** - In managing overdosage, consider the possibility of multiple drug overdoses, interaction among drugs, and unusual drug kinetics in your patient. Unless 5 times the normal dose of cefaclor has been ingested, gastrointestinal decontamination will not be necessary. Protect the patient's airway and support ventilation and perfusion. Meticulously monitor and maintain, within acceptable limits, the patient's vital signs, blood gases, serum electrolytes, etc.

	Related to Drug	Drug Discontinued
Nausea and Vomiting	0.5%	0.3%
Dyspepsia	0.3%	0.1%
Diarrhea	0.7%	0.5%
Rash (including urticaria & morbilliform eruptions)	0.6%	0.3%
Positive Coombs	0.3%	-
Eosinophilia	1.6%	-
Genital moniliasis	0.3%	-
Vaginitis	0.2%	0.1%
Elevated SGOT/Elevated SGPT	0.3%	-
	0.2%	-

be decreased by giving activated charcoal, which, in many cases, is more effective than emesis or lavage; consider charcoal instead of or in addition to gastric emptying. Repeated doses of charcoal over time may hasten elimination of some drugs that have been absorbed. Safeguard the patient's airway when employing gastric emptying or charcoal. Forced diuresis, peritoneal dialysis, hemodialysis, or charcoal hemoperfusion have not been established as beneficial for an overdose of cefaclor. **DOSE AND ADMINISTRATION:** Cefaclor is administered orally. **Adults** - The usual adult dosage is 250 mg every 8 to 12 hours. For more severe infections or those caused by less susceptible organisms, larger doses may be needed. The maximum recommended dosage is 2 g per day, although doses of 4 g per day have been administered safely for 28 days. For lower respiratory tract infections, the dosage should be administered three times daily. For skin and soft-tissue infections, the dosage is 250 mg administered 2 or 3 times daily. **Children** - The usual recommended daily dosage for children is 20 mg/kg/day in divided doses every 8 to 12 hours. For streptococcal pharyngitis or tonsillitis and soft-tissue infections, the total daily dosage may be divided and administered every 8 to 12 hours. In more serious infections, otitis media, and those infections caused by less susceptible organisms, 40 mg/kg/day is recommended, up to 1 g per day. For otitis media, the total daily dosage may be divided and administered every 12 hours. For lower respiratory tract infections, the total daily dosage should be divided and administered 3 times daily. In the treatment of  $\beta$ -hemolytic streptococcal infections, a therapeutic dosage of CECLOR should be administered for at least ten days. Most clinical studies were performed with a duration of therapy between five and fourteen days. **DOSE FORMS:** CECLOR 250 mg Pivules 3061 - Each opaque purple and white capsule contains 250 mg cefaclor: available in bottles of 100 and 250 capsules. CECLOR 500 mg Pivules 3062 - Each opaque purple and grey capsule contains 500 mg cefaclor: available in bottles of 30 and 100 capsules. CECLOR 125 mg for Oral Suspension (M-5057), 25 mg/mL - Reconstitute by adding 60 mL of water to each 100 mL bottle or 90 mL to each 150 mL bottle. Shake well. Each 5 mL dose of strawberry-flavored suspension contains 125 mg cefaclor. CECLOR 250 mg for Oral Suspension (M-5058), 50 mg/mL - Reconstituted by adding 60 mL of water to each 100 mL bottle or 90 mL to each 150 mL bottle. Shake well. Each 5 mL dose of grape-flavored suspension contains 250 mg cefaclor. CECLOR 375 mg for Oral Suspension (M-5132), 75 mg/mL - Reconstitute by adding 42 mL of water to each 70 mL bottle or 60 mL to each 100 mL bottle. Shake well. Each 5 mL dose of grape-flavored suspension contains 375 mg cefaclor. After mixing, store in refrigerator. The mixture may be kept for 14 days without significant loss of potency. Shake well before using. Keep tightly closed. Product monograph available on request.

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