

Letters to the Editor

The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

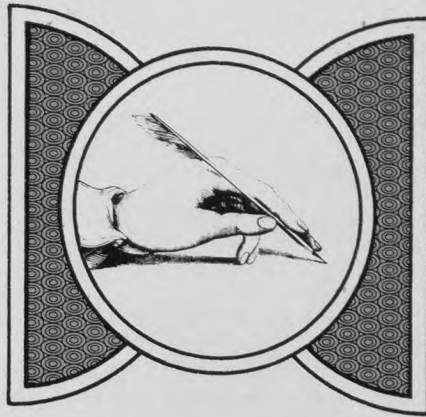
Flexible Sigmoidoscopy

To the Editor:

Having been one of the initial advocates of flexible sigmoidoscopy in family practice programs, I am pleased to see my colleagues from the University of Louisville making a contribution in this area (Steiner RP, Holtzapple KE, Dickstein H, et al: *Colonic polyps and colon cancer. J Fam Pract* 17:983, 1983). The American Cancer Society recommends performance of sigmoidoscopy every three to five years only after two negative examinations are done annually.¹ These initial two annual examinations were omitted from the tables and text of the article by Dr. Steiner and colleagues.

Regarding the patient R.W., there is mention of two polyps retrieved. One is described as being hyperplastic. Although it is not described in the text, I assume that the other one was an adenoma, since it was described as a pedunculated polyp. Furthermore, the size of 1.2 cm is unusual for a purely hyperplastic polyp. These are more frequently described as being 5 mm in diameter.²

Winawer et al³ have performed sensitivity studies on guaiac cards with and without rehydration. It is their recommendation that the slides not be rehydrated because of an unacceptably high number of false positives. A community-based study by Frame and Kowulich⁴



found that without rehydration, sensitivity dramatically dropped. Since controlled trials are still ongoing, this remains an open question. The need for increasing the sensitivity of the test by rehydration may hinge on storage time. Slides returned within four days may have sufficient sensitivity to preclude rehydration and the \$700 consequence of a false positive.

Finally, the statement by Dr. Holtzapple regarding the lack of acceptance of rigid sigmoidoscopy by patients and physicians bears repeating. A submitted paper⁵ examines the implications of this statement in further depth. Ironically, neither of the patients described in the Grand Rounds received a sigmoidoscopic examination.

Wm. MacMillan Rodney, MD
Vice-Chairman, Department of
Family Practice
San Bernardino County
Medical Center
San Bernardino, California

References

1. Steiner RP, Holtzapple KE, Dickstein H, et al: *Colonic polyps and colon cancer. J Fam Pract* 17:983, 1983
1. Rodney WM, Quan MA, Johnson RA, Beaber RJ: Impact of flexible sigmoidoscopy on physician compliance with colorectal cancer screening protocol. *J Fam Pract* 15:885, 1982
2. Rodney WM, Quan MA, Chan KC: Colorectal cancer: Pathogenesis, natural history of the disease, and management of polyps. *Sem Fam Med* 2(4):256, 1981
3. Winawer SJ, Fleisher M, Baldwin M, Sherlock P: Current status of fecal occult blood testing in screening for colo-

rectal cancer. *CA* 32:100, 1982

4. Frame PS, Kowulich BA: Stool occult blood screening for colorectal cancer. *J Fam Pract* 15:1071, 1982

5. Rodney WM, Felmar E: Why flexible sigmoidoscopy versus rigid sigmoidoscopy. Presented at the American Academy of Family Physicians—American Society for Gastrointestinal Endoscopy Conjoint Course on Flexible Sigmoidoscopy, Los Angeles, Calif, September 24, 1983

The preceding letter was referred to Dr. Steiner, who responds as follows:

We appreciate Dr. Rodney's comments regarding our Family Practice Grand Rounds article, "Colonic Polyps and Colon Cancer." Our replies to these comments follow:

1. We are certainly aware of the American Cancer Society's recommendation for sigmoidoscopy every three to five years after two normal annual examinations beginning at age 50. We regret not mentioning this in the text or table.

2. Both polyps retrieved from patient R.W. were hyperplastic.

3. There is no question about the large number of false-positive slides obtained with rehydration when strict dietary control is not part of the stool collection protocol. The optimal procedure mentioned in our article made use of a low-peroxidase diet.¹ With adherence to such a diet, hydration of the slides does not create a significant number of false positives, and the sensitivity of the test for detecting occult blood is enhanced. Winawer and his group make note of this fact in their review article quoted by Dr. Rodney.²

4. Although it can be legitimately argued that sigmoidoscopy should always precede barium enema studies, this did not occur with the two patients presented, as the barium enema findings seemed

Continued on page 432

Continued from page 429

to call for colonoscopy rather than any sort of sigmoidoscopic procedure.

R. Prasaad Steiner, MD

Associate Professor

Department of Family Practice

University of Louisville

Louisville, Kentucky

References

1. Macrae FA, St. John DJB, Caligiore P, et al: Optimal dietary conditions for hemoccult testing. *Gastroenterology* 82: 899, 1982
2. Winawer SJ, Fleisher M, Baldwin M, Sherlock P: Current status of fecal occult blood testing in screening for colorectal cancer. *CA* 32:100, 1982

Patient Desires and Expectations of the Family Physician

To the Editor:

The article by Schwenk et al (Schwenk TL, Clark CH, Jones GR, et al: *Defining a behavioral science curriculum for family physicians: What do patients think?* *J Fam Pract* 15:339, 1982) suffers from a conceptual confusion between patient expectations and patient desires. Although the two are similar, they are by no means identical, and in some cases they differ markedly; the terminal patient may desire a miraculous cure but expects to die.

Schwenk and his colleagues wrote as though they were studying patient desires. For example, it was the lack of studies on "the needs and desires for specific psychosocial skills in family physicians" (p 340) that apparently motivated the research in the first place. One of the criteria guiding the construction of the questionnaire was to allow the patient "a range of choices when deciding how much involvement he or she might desire from a family physician on any given psychosocial problem"

(p 341). But the actual wording to which patients responded was: "For the following problems, my family physician would: Level 1: not be involved; if I sought help, it would be elsewhere." (Levels 2 through 4 describe increasing degrees of involvement on the part of the physician) (p 341).

The important phrase is "my family physician would." Use of this particular phrase (rather than, for example, "I would want my family physician . . .") seems to call forth an expectation or a prediction of the physician's usual behavior regardless of whether that behavior is demanded, desired, or decried. It is unjustified to interpret data derived from answers to this question as indicative of preferences, desires, or the like. Yet this is exactly what seems to have happened: "The items in level 2 were those for which subjects desired a specialist. . . . [P]atients in this study population with marriage problems are not nearly so interested in consulting family physicians . . ." (p 342).

If, as Schwenk later wrote, the authors wished to design a behavioral science curriculum responsive to patient desires,¹ they have not done so. The whole point of empirical research is to let the data have their say. Findings, justified or not, have a life of their own. It is unfortunate when the investigator incorrectly interprets his findings to criticize the work of others as Schwenk² has done. It is more serious when the editor of a prestigious journal uses incorrectly interpreted data as part of an argument for particular policy recommendations.³

Robert J. Wolosin, PhD
Family Practice Residency
Program
Memorial Hospital
South Bend, Indiana

References

1. Schwenk TL: Behavioral science in family medicine, letter. *J Fam Pract* 16: 675, 1983
2. Schwenk TL: Pediatric training in family practice, letter. *J Fam Pract* 17:579, 1983
3. Geyman JP: Public perceptions of psychosocial problems and roles of the family physician. *J Fam Pract* 15:225, 1982

The preceding letter was referred to Dr. Schwenk, who responds as follows:

My co-authors and I agree that the distinction between patient desires and patient expectations is critical to the interpretation of the study's results. While we would not want to excessively encourage patient-respondents to express desires, since this might encourage requests on their part for a physician who could be "all things to all people," we would want their honest opinion as to ideal family medical care. Our description of methods did not highlight our efforts in this regard, but we wish to make clear that in the verbal introduction of the questionnaire we explicitly requested that patients express desirable aspects of family medical care rather than their expectations of reality. We would be pleased to make available to anyone who is interested this standard explanation and verbal introduction that was used in our study.

Since this distinction has been made frequently by others in informal discussion, we appreciate the opportunity to clarify a misconception regarding the distinction between patient expectations and patient desires.

Thomas L. Schwenk, MD
Assistant Professor
Department of Family and
Community Medicine
University of Utah
Salt Lake City, Utah