The Maturing of Family Medicine: Challenges to Behavioral Science

Johanna Shapiro, PhD
Orange, California

In recent years much has been written about the evolving nature of family medicine as it seeks to come of age in a time of great societal demands and shrinking fiscal resources.[1] The paradigm shift[2] in the world of medicine (away from exclusive focus on subspecialty medicine and toward a biopsychosocial understanding of the patient as a whole person) that created the specialty has given way to other paradigm shifts. One current trend emphasizes academic rigor, scholarly productivity, and the development of scientifically sound research directions. Reflecting a completely different emphasis, another paradigm shift has occurred toward "gatekeeper economics." These developments pose formidable challenges to family physicians, and the changing face of family medicine has profound implications for behavioral scientists as well.

At issue is what role behavioral scientists will play in helping to shape the future of family medicine. Interdisciplinary integration has been a much-sought-after but elusive goal for both behavioral scientists and family physicians over the last 15 years.[3] Too often, despite the best intentions of all concerned, the behavioral scientist has been relegated to the role of helpful handmaiden. If this role persists unchallenged into the maturational phase of family medicine, there is little hope of ever achieving the integration of physician and nonphysician that was inherent in the earliest visions of the specialty.[4] In considering both the dangers and possibilities that await behavioral science in the future, two arenas reflecting the abovementioned paradigm shifts must be addressed forcefully.

Nature of Research: Is Scholarly Rigor Only of One Type? Family medicine's recent quest for academic legitimacy,[5] while a much-needed, essential step in the lifecycle development of the specialty, is also subject to potential distortions from the viewpoint of behavioral science faculty. The behavioral scientist, usually with a strong background in research design and methodology, suddenly may become at risk for fulfilling in unquestioning or mechanical fashion the research fantasy of a department (in a sense becoming a department's research justification). New behavioral science faculty may be recruited only for their impressive research vitae, for the grants they can bring to the department, with insufficient attention paid to their long-term commitment and overall understanding of the field of family medicine. Such a role for behavioral scientists can easily isolate them from the broader training functions and vision that form the core of any department. Thus there is a potential tendency to see behavioral scientists as a means to an end, in this case the production of data and publications, instead of part of an interwoven, collaborative context.

For their part, behavioral scientists must also be prepared to rethink their traditional research methods and previous research interests. In the early years of family medicine, it quickly became apparent that behavioral science clinical skills could not be arbitrarily transplanted into family medicine soil or grafted in their original form onto family medicine residents. Similarly, behavioral scientists must not ignore the chance to explore and experiment with innovative research approaches and questions that capture the essence of their adoptive specialty, simply out of a desire to satisfy the research expectations of the medical community at large. It is possible that the quantitative-agrarian methodology may have its limitations when applied to family medicine.[6] The research questions considered fascinating by health psychology professionals may be only tangential to family medicine's most pressing concerns. Thus, pressures to churn out research in bulk must be avoided; instead, behavioral scientists should work closely with family physicians to develop a strong theoretical context and methodological foundation that can inform family medicine as a truly unique forum for scientific inquiry.[7]

Clinical Teaching: Techniques in the Context of Self-understanding and Caring. In terms of clinical teaching, family medicine originated as a specialty characterized by a committed focus on the patient as a whole person existing

Submitted, revised, January 20, 1988.

From the Department of Family Medicine, University of California, Irvine, Orange, California. Requests for reprints should be addressed to Johanna Shapiro, Department of Family Medicine, University of California, Irvine, 101 The City Drive South, Orange, CA 92668.

transformationally in the context of family, community, and culture.[8,9] Now, however, there are multiple pressures emerging from the gatekeeper role in the health care system to practice high-volume, compartmentalized medicine. A potential consequence of the bottom-line approach to the practice of medicine is the pressure for the behavioral scientist to provide quick fixes for, if not the patient's problems, at least the physician anxiety engendered by the patient's problems,[10] to be able to boil down complex theory into a few palatable tricks or stratagems, and to be willing to serve up cookbook-like responses to common patient problems. If the physician-patient relationship receives attention, it is increasingly in the context of learning to utilize interpersonal skills to avoid malpractice suits.[11]

In the enthusiastic rush toward claiming its rightful place among other medical specialties, there is the danger that family medicine will leave behind its concern for the phenomenological experience of the patient[12] and the essential vulnerability of the physician.[13] It is critical that the behavioral scientist, as clinical teacher, not be suborned by this trend. Rather, the teaching function of the behavioral scientist must continue to be helping residents learn how to assume empathetically some of the patient's sufferings and concerns,[14] to distinguish between the voice of medicine and the voice of the real world,[15] and to probe their own life histories, which inevitably color interactions with patients.[16]

Although it is infinitely easier, because it dovetails so conveniently with contemporary high-technology, subspecialized approaches to medical education, an exclusive focus on transmitting simply the technology of behavioral science must be avoided. In providing physicians with skills, it is also the behavioral scientists' responsibility to help physicians understand the context in which those skills must be exercised, the unstated anxieties, implicit meanings, and subjective interpretations that exist whenever a physician and patient come together in an I–Thou encounter.[17] Potentially rich and useful techniques such as the genogram or the Family APGAR remain only techniques when isolated from a larger context of understanding and compassion.[18]

SUMMARY

For family medicine to maintain the unique creativity and risk taking that were present at its inception, behavioral scientists must be allowed to play, and be willing to assume, an essential role in the ongoing process of defining the field of family medicine, formulating its assumptions and asserting its future direction both in terms of academic research and clinical teaching. As co-creators and co-inspirers, behavioral scientists have the rare challenge of synthesizing their perspectives and values with those of the physicians with whom they work. It is to be hoped that through this interactive process, the practice of family medicine will continue to be an experience of real healing and wholeness for both patients and physicians.

References

1. Scherger J: Priorities in family medicine: Residency training. Fam Med 1987; 19:177–179
2. Kuhn TS: The Essential Tension: Selected Studies in Scientific Tradition and Change. Chicago, University of Chicago Press, 1977
3. Shapiro J: A revisionist theory for the integration of behavioral science into family medicine departments. J Fam Pract 1980; 10: 275–282
4. Johnson AH: Behavioral science in family practice: An ethical imperative. J Fam Pract 1977; 4:525–528
5. Colwill JM: Academic departments of family medicine: A retrospective and a prospective view. Fam Med 1986; 18:384–388
6. Kuzel AJ: Naturalistic inquiry: An appropriate model for family medicine. Fam Med 1986; 18:369–374
7. Gordon MJ: Research traditions available to family medicine. J Fam Pract 1978; 7:59–68
8. McWhinney IR: An Introduction to Family Medicine. New York, Oxford University Press, 1981
9. Ransom DC: The evolution from an individual to a family approach. In Henad S, Grose NP (eds): Principles of Family Systems in Family Medicine. New York, Brunner/Mazel, 1985, pp 5–23
10. Stein HF: The influence of countertransference on decision-making and the clinical relationship. Cont Educ Fam Physician 1983; 18: 625–630
11. Beck JT: Teaching Residents How to Avoid Malpractice Suits. Presented at the 20th Annual Meeting of the Society of Teachers of Family Medicine, New Orleans, April 25–29, 1987
12. Sarason SB: Caring and Compassion in Clinical Practice. Jossey-Bass Publishers, San Francisco, 1985
13. Maslach C: The cost of caring. In Farber BA (ed): Stress and Burnout in the Human Service Professions, New York, Pergamon, 1983
14. Napodano RJ: Values in Medical Practice. New York, Human Sciences Press, 1986
15. Mischler EG: The Discourse of Medicine: Dialectics of Medical Interviews. Norwood, NJ, Ablex, 1985
16. Crouch M: Working with one's own family: Another path for professional development. Fam Med 1986; 18:93–98
17. Buber M: I and Thou, ed 2. Kaufman W (trans). New York, Scribner, 1958
18. Hilfiker D: Unconscious on a corner. JAMA 1987; 258:3155–3156

Manual of Pediatric Emergencies. *Joseph R. Zanga (ed). Churchill Livingstone, New York, 1986 (printed 1987), 511 pp., $38.50 (paper).*

This manual will be useful as a reference book for family physicians, pediatricians, and emergency physicians who treat children. Its succinct outline format presupposes some familiarity with the topics discussed; thus, it may not be sufficient as a primary reference for medical students.

The book covers a comprehensive list of topics selected from "a review of the author's experience in [an] inner-city pediatric emergency department," plus some topics pertinent to rural practice. Each topic is treated in outline form under the following headings: definition, history, clinical presentation, "keys to diagnosis" (including tests to order, and differential diagnosis), emergency department (ED) management, post-ED care and follow-up, common complications, and suggested readings.

These short bibliographies form an important expansion on the limited text. There are virutally no illustrations, which might have enhanced the descriptions of certain procedures. Many chapters do include algorithms and tables, which often provide detailed reference material augmenting the succinctly outlined text.

The best chapters, such as those on poisoning, shock, or asthma, are those that emphasize the steps to diagnosis and give detailed information on management of the problem. Not all chapters are of this quality. Several chapters suffer from vacuous generality or virtual omission of recommendations for diagnosis or management of the problem.

Most of the authors of individual chapters practice in "acute care settings"; their bias toward accomplishing everything in the emergency department is manifest. Most chapters include very little information about "post-ED care." For example, when dealing with minor burns, the authors recommend referral to an "outpatient burn clinic" for follow-up. Several chapters do contain recommendations for crisis intervention with families.

In general, this book will be valuable as a reference in the emergency situation, especially for serious or uncommon problems, but will not follow the primary care physician into his or her office for prevention or follow-up of emergencies.

Louise Acheson, MD, MS
Case Western Reserve University
Cleveland, Ohio

Case Presentations in Clinical Geriatric Medicine. *G. S. Rai, P. J. Murphy, G. Wright. Butterworths, Stoneham, Massachusetts, 1987, 136 pp., $21.95 (paper).*

Case Presentations in Clinical Geriatric Medicine endeavors to illustrate the unique aspects of geriatric medicine through case presentations. The manual is divided into two sections: the first consists of 60 cases with questions; the second, answers to the questions and discussions of the cases. As such, the book is stimulating and fun, as readers have the opportunity to analyze the cases and compare their differential diagnoses and management plans with those of the authors.

The authors acknowledge that the 5 × 8-in, 6.5-oz book is not a comprehensive guide to geriatrics. They intend it for trainees, physicians treating elderly patients, and physicians preparing for examinations. Trainees should be aware that some of the patient management suggestions are controversial, as globally acknowledged in the preface rather than in the individual case discussions. Advanced readers should be aware that the cursory discussions serve to identify some gaps in knowledge with references for further reading.

The unillustrated text is easy to read, with lists for laboratory values lending a spacious feel to the pages. The index is satisfactory. The references for further reading are current, but have a tendency to rely on British literature.

While the cases are fun, the potential buyer should be aware of some minor annoyances. The book is written in British English. Hence, drug names (Frumil, diclofenac), measurements (one stone), and social settings (Part III accommodation) may be unfamiliar. Laboratory values are reported in SI units, with normal ranges rarely included. There are a few editing lapses in which discussions include diagnoses not relevant to the case or in which abnormal laboratory studies are not discussed. Finally, a number of cases only serve to illustrate that diseases more commonly associated with younger patients (asthma, Crohn's disease) may first manifest themselves in the aged.

Gary N. Fox, MD
The Reading Hospital and
Medical Center
Reading, Pennsylvania

Soft Tissue Rheumatic Pain: Recognition, Management, Prevention (2nd Edition). *Robert P. Sheon, Roland W. Moskowitz, Victor M. Goldberg. Lea & Febiger, Philadelphia, 1987, 332 pp., $42.50.*

Don't let this book's title deceive you; it may sound specialized and esoteric, but it is about the complaints heard in examining rooms every day: low back pain, tendonitis, bursitis, fibrositis, shin splints, and so on. Drawing from several specialties and disciplines, the authors meld the information into one complete, thorough reference. Though quite clinically oriented and practical, it is also scholarly and intellectually based, emphasizing firm knowledge of anatomy and physiology, intensive examination, and precise diagnosis as the keys to successful treatment.

I had intended to skim, but found myself reading in detail, wishing I had found such a resource years ago. One point appears repeatedly: the key to successful treatment is accurate diagnosis. The section on cervical spine syndromes was disjointed, but many others (rotator cuff disorders, frozen shoulder, and tennis elbow, for instance) are excellent. The chapter on low back pain is outstanding; it is up to date, using concepts from the Volvo study and other recent European work, and provides a comprehensive management approach. It is supported by 233 references dating from 1934 to 1986.

There are many well-planned, clear

illustrations, both drawings and photographs. The index is very helpful, including such entries as Dawbarn's sign, xiphoiditis, and writer's cramp. The binding is durable and professional in appearance.

I recommend this book for all family physicians and residents who treat aches and pains; it cries to be carried right into the examination room for physician reference and for patient education.

Robert H. Rozendal, MD
Bremerton, Washington

Emergency Pediatrics: A Guide to Ambulatory Care (2nd Edition). *Roger M. Barkin (ed), Peter Rosen (Assoc Ed). C. V. Mosby Company, St. Louis, 1986, 690 pp., $38.50 (paper).*

This book serves as a resource for quick reference to a wide variety of information needed for caring for emergencies in infants and children. Problems are discussed both from the standpoint of presenting complaints and diagnoses. For the presenting complaints for which the diagnosis may not be clear, the emphasis is on initial stabilization and differential diagnosis, using a tabular format to guide the reader to the appropriate diagnosis-specific chapters for more detailed information.

Specific sections deal with neonatal emergencies, advanced cardiac life support, fluid and electrolyte balance, environmental emergencies, poisoning, and trauma. An excellent appendix includes instructions for parents, instructions for performing nine common emergency procedures, and a formulary.

The book is organized so as to be readily accessible in an emergency situation. Tables, highlighting, and flow charts all help in rapid decision making. It is not (nor is it meant to be) comprehensive in its coverage of the topics.

An acceptable way of handling problems acutely is presented, without room for discussion of alternatives, controversies, or long-term follow-up. It is written in a setting where a variety of specialists are readily available and thus advises specialty referral for problems many in family practice would manage primarily. Nonetheless, the information contained is adequate to carry management through the initial critical period.

This book would be very useful to the practicing family physician or resident in the emergency room setting. Its terseness, however, would limit its use as a textbook for medical students.

Fred Heidrich, MD, MPH
Seattle, Washington

Rhythm Quizlets: Self-Assessment. *Henry J. L. Marriott. Lea & Febiger, Philadelphia, 1987, 189 pp., $16.50 (paper).*

Rhythm Quizlets: Self-Assessment, the latest of Dr. Marriott's texts, should prove to be as valuable and widely used as his previous publications. This book will be useful for practicing family physicians, residents in training, medical students, and coronary care nurses.

The text is subdivided into three sections demonstrating rhythm or conduction disturbances of increasing complexity. The first section contains problems for the beginner's assessment, and the last section consists of advanced and intricate tracings requiring considerable knowledge and skill to avoid pitfalls and traps. The book's format lends itself to self-instruction, with tracings printed on the left-hand page and interpretations on the right so they can be kept out of sight while studying the arrhythmia.

The illustrative tracings are clearly reproduced and readable. The comments on each tracing include diagnoses, which are confined to the arrhythmias, the blocks, and the main diagnostic features of each as well as special points, which include the rationale for the diagnosis, notes about the mechanism, or a warning about a hidden trap. Comment is occasionally, but not routinely, provided on treatment, particularly where there is a risk of misguided therapy, or if there seems to be some other good reason to do so.

Medical students in their clerkship years and other health professionals will find this book useful as an intro-

continued on page 588

continued from page 586

duction to arrhythmias; however, there is very little reference to basic anatomy and physiology. For others, it will serve as an office reference or as a source for review by those with more sophisticated knowledge and clinical experience.

Robert E. McArtor, MD, MPH
Northeastern Ohio Universities
College of Medicine
Rootstown, Ohio

Handbook of Skin Clues of Systemic Diseases. *Paul H. Jacobs, Todd S. Anhalt. Lea & Febiger, Philadelphia, 1987, 123 pp., $9.95 (paper).*

The authors of this manual list 20 cutaneous clues to systemic disease. Each clue is followed by a list of differential diagnoses to be considered. On a facing page are listed common manifestations or specific laboratory procedures to consider for each diagnosis.

The manual is designed for quick recovery of information for each dermatologic clue presented.

This manual was easy to use, succinct, and useful in focusing quickly upon a differential diagnosis of a given dermatologic problem. The indexing of the text was extremely well done, making the manual more valuable.

This manual would complement other reference dermatology texts and would be useful to all primary care physicians. The handbook was cleverly constructed and could be used effectively to recognize many systemic diseases from their dermatologic presentation.

Fran S. Larsen, MD
Ventura County Medical Center
Ventura, California

Cope's Early Diagnosis of the Acute Abdomen (17th Edition). *William Silen. Oxford University Press, New York, 1987, 290 pp., $24.95, $14.95 (paper).*

This 17th edition of *Cope's Early Diagnosis of the Acute Abdomen* fully updates a classical medical textbook. The author has gone to great lengths to preserve Dr. Cope's original concept of surgical diagnosis being made through a complete history and physical examination. This textbook, published in paperback form, is relatively inexpensive and yet filled with important observations that have application for the family physician.

It is well organized, extremely readable, and has supplemental roentgenogram and ultrasound studies that relate to the clinical presentations. Woven throughout is the recurring theme that not all "acute abdomens" require operation, and that this important decision is usually made on clinical grounds rather than on laboratory investigation.

This book certainly is a mainstay of surgical diagnosis for medical students. As its title indicates, it stresses to the student the need for early, but correct, surgical diagnosis. Also of great appeal to the practicing physician and resident, this classical textbook should be part of everyone's medical library.

David A. Driggers, MD
Family Practice Residency Program
Casper, Wyoming

Obstetrics and Gynecology (8th Edition). *William J. Ledger, Russell K. Laros, Jr., John H. Mattox, J. Robert Willson, Elsie Reid Carrington (eds). C. V. Mosby Company, St. Louis, 1987, 754 pp., $39.95.*

This very readable reference textbook, composed of 49 chapters, addresses energetically the wide range of topics in obstetrics and gynecology. It is written especially for medical students, residents in family practice and obstetrics and gynecology, family physicians, and others who seek a comprehensive text of basic principles. The text is concisely written and provides the reader with only essential information. Helpful references are listed at the end of each chapter to direct the reader to additional material. The illustrations are of high quality, are numerous, and support the text very well. Chapters not often found in similar textbooks include pediatric gynecology, psychology and life changes, sexual response, and sexual assault.

Some of the chapters are a bit su-

perficial, a risk in writing such a comprehensive text. The section on family planning, for example, devotes only a few pages to oral contraceptives, and for those who plan to first-assist at surgery, there is little detailed information on surgical technique. For those commonly used procedures, such as episiotomy and forceps-assisted delivery, however, it is excellent.

The editors have succeeded in their goal: to provide a reference text for specialists other than obstetricians-gynecologists that broadly and economically encompasses the field. The information is presented succinctly and in sufficient detail to meet the needs of most family physicians and residents.

Lee A. Norman, MD
Swedish Hospital Medical Center
Seattle, Washington

Office Management of Sports Injuries and Athletic Problems. *Morris B. Mellion (ed). Hanley & Belfus, Philadelphia, 1988, 320 pp., $39.95.*

In contrast to other recent texts on sports medicine, this book is written for the office-based physician who cares for athletes of all types, competitive or recreational. As the editor correctly states, the vast majority of sports medicine is practiced in the physician's office. This text concerns itself with not only the school-age athlete, but devotes considerable attention to the beyond-college-age patient who is involved in recreational athletics.

Entire chapters are devoted to such diverse topics as the physically active diabetic, the athletic woman, and sports nutrition. Approximately one third of the book is concerned with specific injuries and the diagnosis and treatment thereof. The chapter on the office management of knee injuries is excellent.

This book is unique in that a great deal of information is imparted to the reader. Such diverse topics as the treatment of plantar warts, athletic pseudonephritis, and the most effective drugs in exercised-induced asthma are included; however, this book does not discuss in great depth such subjects as fracture treatment or surgical management of injuries.

The printing and quality of the illustrations all make this book very easy to read. This book should be in every family physician's library, especially if he or she is taking care of athletes of any type or age.

Arnold N. Krause, MD
Cheyenne, Wyoming

Common Diagnostic Tests: Use and Interpretation. *Harold C. Sox, Jr. (ed). American College of Physicians, Philadelphia, 1987, 380 pp., $23.50 (paper).*

This paperback textbook presents many common medical tests in a cost-effective aspect. An example is the author's discussion of throat cultures and rapid tests for diagnosis of group A streptococcal pharyngitis. In this section, the recurring problem of when to culture, when not to culture, and the benefits of presumptive treatment are discussed. This topic is extremely relevant to the family physician, and although the book discusses in detail the sensitivity and specificity of several different tests, the author's ultimate recommendations to the family physician are outstanding.

The many different topics are extremely well organized; however, with an emphasis on statistics and numbers, the readability of the textbook is, at times, somewhat difficult. Nevertheless, if the reader critically analyzes the information presented, it is certainly loaded with clinical "pearls." Scattered throughout the text are appropriate tables and figures that present a great amount of detail.

This book would appeal to the practicing family physician who has an interest in cost-effective care as well as to a resident or other health care student who needs a ready resource on the benefits of certain common diagnostic tests. It would also be an excellent reference for any physician asking why he or she is ordering given tests and what true value will result from them.

David A. Driggers, MD
Family Practice Residency Program
Casper, Wyoming

continued from page 498

oride prescribing for breast-fed infants should begin early on, and we generally initiate fluoride at the first follow-up visit. Our questionnaire, however, did not specify a time frame and only asked "Do you prescribe fluoride supplements for breast-fed infants?" That only 54 percent of family physicians said "yes" indicates a need for greater educational efforts in this area.

Fluoridated water consumed after weaning may be sufficient to "decrease the prevalence of caries in permant teeth." We are just as interested, however, in providing caries protection to the primary teeth, as caries in these teeth are responsible for significant morbidity as well.

Since infants who are fed only ready-to-feed formula get virtually no fluoride whether they live in a fluoridated community or not, we supplement these infants in the same manner we supplement breast-fed infants.

It is true that not all military family physicians practice in a setting that fosters preventive health care. But shouldn't all board-certified family physicians be aware of proper prescribing practices?

We maintain that the safety of prenatal fluoride supplementation has been established. The Food and Drug Administration concurs with this. We agree that further studies on efficacy are needed and hope that this kind of constructive dialogue will stimulate such research. In the meantime we feel there may be sufficient evidence of efficacy to merit consideration of supplementation in the informed patient.

John C. Rigilano
Captain, USAF MC
Edward M. Friedler
Major, MC,
Larry J. Ehemann
Colonel, USAF MC
Department of Family Practice
Uniformed Services
University of the Health Sciences
Bethesda, Maryland

PAP SMEAR SCREENING

To the Editor:

Screening for disease is integral to our ability to predict and prevent problems in predisposed individuals. This may well become the ultimate challenge to physicians as we merge toward the close of the century and a dawning of a new era in medicine.

I congratulate Hamblin et al *(Hamblin JE, Brock CD, Litchfield L, Dias J: Papanicolau smear adequacy: Effect of different techniques in specific fertility states. J Fam Pract 1985; 20:257–260)* for their excellent study on gynecologic cytology screening, specifically the collection of ecto- and endocervical cells. The research design was organized, quite easy to comprehend, and a logical follow-up of a 1981 study that appeared in this journal.[1]

One error did appear in the article related to the authors' definition of test sensitivity, which is the number of true-positive tests divided by the true positives plus the false negatives (not false positives).[2] Decreasing the number of false-negative Pap smears does increase the sensitivity of the Pap smear, which was the authors' purpose in researching the topic. Thank you for printing these valuable findings.

Chris Pederson, MD
Health Appraisal Clinic
City of Faith Medical
and Research Center
Tulsa, Oklahoma

References

1. Colon VF, Linz LE: The extended tip spatula for cervical cytology. J Fam Pract 1981; 13:37–41
2. Mausner JS, Kramer S: Epidemiology—An Introductory Text, ed 2. Philadelphia, WB Saunders, 1985, p 220

LETTERS TO THE EDITOR

NICOTINE CHEWING GUM AND SMOKING CESSATION

To the Editor:

Allen F. Shaughnessy, Robert E. Davis, and C. Eugene Reeder have provided valuable information in their article, "Nicotine Chewing Gum: Effectiveness and the Influence of Patient Education in a Family Practice" *(J Fam Pract 1987; 25:266–269)*. They have demonstrated that family physicians must do much more than just provide a prescription when they wish to help their smoking patients quit smoking. In my practice during the first year after nicotine resin became available in this country, I found that the additional therapeutic component needed was repeated office follow-up visits, initially on a monthly basis.[1] By treating smoking cessation as a desirable behavioral modification, and by establishing a follow-up program similar to the one I used for weight reduction by obese patients, I was able to assist 37 percent of 35 patients (40 percent of 15 men and 35 percent of 20 women) to remain free of cigarette smoking for one year.

These results compare more favorably with the results obtained in smoking withdrawal clinics in this country and elsewhere than do the results obtained by Shaughnessy et al. Return visits to the office give patients the opportunity to discuss side effects, to ventilate their irritations occasioned by giving up the pleasures that previously accompanied their smoking, and to receive support in their efforts to quit smoking from the physician and his office staff. In my practice a prescription for each month's supply of nicotine chewing gum was given only at the end of such visits in the same way in which dieters received diuretics, appetite suppressants, and behavior modification goals only on regular follow-up visits. For both types of patients, when three or four monthly visits had been completed successfully, return visits could then be spread out to six, eight, or 12 weeks. Return office visits can be scheduled easily in the family practice setting and should be offered to patients who wish to stop smoking but do not wish or are unable to enter a formal smoking withdrawal clinic.

I would encourage Shaughnessy et al to conduct a follow-up study, on a scale as large as their present study, in which family physicians would monitor the progress of one study group with return office visits regularly scheduled, prescribing enough nicotine resin each time to last only until the next visit. I believe such a study would show a significant difference between the percentage of the study group and the control groups who would stop smoking.

Duane A. Lawrence, MD
Virginia Beach, Virginia

Reference

1. Lawrence DA: An initial experience with Nicorette and smoking behavior in a family practice. Virginia Fam Phys 1986; 36:23

COMMUNITY-BASED FAMILY PRACTICE RESIDENCY AND HMO

To the Editor:

As a community-based program affiliated with the University of North Carolina, we read with interest the article "Impact of an HMO on a University-Based Family Practice Program."[1] Greensboro, unlike Chapel Hill, is not primarily a college community. Our residency program consists of 16 residents and four faculty. In May of 1985 we also decided to participate in the Blue Cross/Blue Shield Personal Care Plan. Although our experiences somewhat differ from that of Chapel Hill, the impact of our participation in this HMO on our residency program has been similar.

At the onset of participation we limited our enrollment to 1,500 patients. We sought enough patients to provide an educational experience in prepaid care, but not so many as to be viewed as competitors by the private physician community, many of whom serve as voluntary teachers for our residency program. This restriction moderated the growth in Personal Care Plan (PCP) patients, and during our first year of participation, total patient visits increased 9 percent. Currently, all visits to our center are 23 percent greater than at the time of enrollment, and we are capitated at 1,233 PCP patients. PCP patients account for most of our 50 percent increase in new patient visits in fiscal 1986, and during the first six months of fiscal 1987, new visits grew by another 50 percent.

The 23 percent increase in patient numbers has stressed workloads for office, clinical, and physician staff. In addition to improving our office efficiency, we have found that we need one full-time equivalent (FTE) to work on PCP claims. This, in effect, leaves us understaffed by 1 to 1.5 FTE. Similar to the experience at Chapel Hill, we have seen increasing demands for laboratory (particularly in-house), x-ray, and health maintenance examinations that include Papanicolaou smears. In the past six months referrals of PCP patients have exceeded predicted levels by 10 to 20 percent. Physician schedules generally are filled several weeks in advance, and we have encountered problems in seeing acute work-in visits. This load has been assigned to faculty and all levels of residents. Every physician is seeing a proportional increase in patients with the change being somewhat greater for faculty. Generally, our residents are scheduled for more patients than we feel is educationally ideal.

In reviewing our experience, our faculty feels that exposure to a health maintenance organization teaches valuable lessons about dealing with

ERRATUM

In Dr DeGruy's reply to Drs. Replogle and Eicke (*Replogle WH, Eicke FJ: Somatization disorder, letter, DeGruy F, reply. J Fam Pract 1988; 26:250, 252, 334*), the word *not* was inadvertently omitted. The second sentence of the third paragraph, p 334, should read: "These data were intentionally not subjected to the sort of interpretation that statistical testing would allow." The editor regrets this error.

prepaid care. Residents are seeing a new patient population from a higher socioeconomic level. These patients have a different health agenda, which places more emphasis on preventive screening than our traditional practice population. Our practice has benefited by having to make critical improvements in efficiency to adapt to a greater workload. A final important benefit has been a marked improvement in clinical revenues at a time when residency funding steadily faces more challenges.

Karl B. Fields, MD
Dennis A. Taylor, MA
Thomas A Cable, MD
Family Practice Center
Greensboro, North Carolina

Reference

1. Curtis P, Sloat S, Aluise J, et al: Impact of an HMO on a university-based family practice program. J Fam Pract 1988; 26: 89–95

SCREENING FLEXIBLE SIGMOIDOSCOPY

To the Editor:

I wish to refer to the articles by Drs. Rodney and Frame (*Rodney WM: Screening flexible sigmoidoscopy: Is it worthwhile? An affirmative view. Frame PS: An opposing view. J Fam Pract 1987; 25:601–607*). I am inclined to agree with all of Dr. Rodney's assertions. Based on a relatively small series of screening flexible sigmoidoscopies in our practice, which is part of a residency training program, I feel primary care physicians need to adopt a more persuasive role, if not an aggressive role, in promoting the existing screening tools available.

Academic procrastination, dilemma, and debate are likely to continue for years to come. At the realistic level, the physician is committed to primary and secondary prevention. Primary prevention methods require extensive research. Reliance therefore is mainly on secondary methods of prevention. The physician and the unsuspecting patient have no other choice! Hence, Dr. Frame's assertion that there is little evidence to show that a significant proportion of asymptomatic people will comply with screening flexible sigmoidoscopy is only partially true. What role physician attitude plays in this noncompliance is a serious question.

Routine screening according to Dr. Frame would place severe time demands on the physician. If their practices are so busy, then they need to refer their patients for screening to physicians who are willing to do sigmoidoscopies. Training physician assistants and nurse practitioners is a dilemma, or question, that will raise even greater problems. Under the guise of further data wanted, a good segment of the population remains unscreened and may indeed proceed on to develop serious disease at great

continued on page 616

continued from page 614

cost to the community. It is similar to being "penny-wise and pound-foolish."

J. R. Varma, MD
Medical College of Georgia
Augusta

The preceding letter was referred to Drs. Rodney and Frame, who respond as follows:

I would like to underline the very real risks for family practice associated with the "academic procrastination and debate" mentioned by Dr. Varma. Flexible sigmoidoscopy is only the beginning. This endoscopic skill, which allows early diagnosis for colorectal cancer, is also the gateway to more accurate diagnosis of many other conditions. There will be additional benefits for those who continue to advance their procedural skills, including those not limited to flexible sigmoidoscopy.[1-5]

Furthermore, many university training programs in family practice continue to wither away in regard to various procedural skills. Medical students frequently cannot find a comprehensive family physician even in the Department of Family Practice. Here at University of California, Irvine, family physicians continue to lack for hospital privileges in electrocardiogram interpretation. The surgeons have withdrawn from the teaching of first assisting at surgery. Professional prejudice continues to exist, and it is no wonder that some family medicine leaders now seem receptive to the idea that family practice in the future will be a blend of ambulatory internal medicine and pediatrics.

Skills in procedures such as flexible sigmoidoscopy allow for opportunities in clinical research whereby family physicians can both demonstrate their technical ability and provide cost-effective patient outcomes. This is exactly the type of clinical research ideally suited to networking by front-line family physicians everywhere. To me, the dilemma is the continuing need for clinical research by practicing family physicians. Epidemiologically based skepticism can only perpetuate "*analysis paralysis.*" Family physicians cannot prosper if influential academic family physicians continue to describe an increasingly narrow future for family practice. We are a specialty of breadth. The Renaissance is at hand for those who keep the faith.[6]

Wm. MacMillan Rodney, MD
University of California Irvine
Medical Center
Orange

References

1. Rodney WM: Flexible sigmoidoscopy and the despecialization of endoscopy. J Fam Prac 1986; 23:279–280
2. Corey GA, Hocutt JE, Rodney WM: Prototype study of nasolaryngoscopy outcomes in family practice. Fam Med (in press)
3. Davies TC, Hahn RG, Rodney WM, Curry HB: The use of OB/GYN ultrasound by family physicians. Cont Educ Fam Physicians 1986; 21:335–338
4. Felmar E, Cottam C, Payton CE, Rodney WM: Colposcopy: It can be part of your practice. Primary Care Cancer 1987; 7(4): 13–20
5. Woodliff DM: The role of upper gastrointestinal endoscopy in primary care. J Fam Pract 1979; 8:715–719
6. Rodney WM: The Future of Urban Family Medicine in Urban Family Medicine, Birrer RB (ed). New York, Springer-Verlag, 1987, pp 281–284

In response to the letter by Dr. Varma, I wish to make it quite clear that I do not wish to discourage physicians who desire to do screening flexible sigmoidoscopy. My point is that there are not yet enough data to make screening flexible sigmoidoscopy a "state of the art" recommendation that should be done by all primary care physicians. Indeed, I would note that Dr. Varma does not present any evidence to contradict any of the data I presented in Table 1; rather, his disagreement seems to be based on personal opinion to which he is entitled.

I continue to feel very strongly that recommendations for health maintenance and screening as well as most other areas of medicine need to be based on scientific evidence rather than personal opinion and politics.

Paul S. Frame, MD
Tri-County Family
Medicine Program
Dansville, New York