DOCUMENTATION OF RESIDENT EXPERIENCE

To the Editor:

It is unfortunately the case that most articles on documentation of residents' activities are written by enthusiasts for the practice. Such an orientation leads to an obvious bias in a perspective presented. In the paper by Schneeweiss et al *(Schneeweiss R, Ellsbury K, Montano D, et al: Hospital privileges for family physicians: Documentation of family practice residents' experiences in training. J Fam Pract 1988; 26:178–184),* the bias is evident in their question, "Was documentation helpful for privilege application?"

Such enthusiasm would be benign if it had no adverse consequences. There are, however, several problems involved. Any systematic documentation procedure requires significant effort by residents—already overstressed—and by residency programs. Inevitable noncompliance of residents may result in unwarranted resident anxiety. Furthermore, if documentation becomes a requirement and takes a form of quantification of procedures, the process may backfire. The numbers themselves may be used by accrediting bodies to deny privileges. Typically family physicians will have documented fewer procedures than specialists in other disciplines. It is not implausible that a hostile accrediting body would define the minimum required number of procedures to be higher than that typically documented by the family physician.

Documentation of procedures also gives a false sense of security to educators and hospitals. Because documentation is usually based on a self-report system, it still relies on the integrity of the individual resident to report honestly. Furthermore, even if documentation provided assurance of competence at the time of documentation, it gives no assurance that that competence is maintained. The focus on reporting misses an underlying educational issue, namely, the need to acknowledge one's own limits. By endorsing a system of lists and numbers, we continue to avoid that crucial issue.

Partly because of the enthusiasm of those who promote documentation, residency accreditation requirements are moving toward mandatory documentation. We see this as unwarranted. Our program does not require documentation, and in our most recent survey of graduates, we found no evidence of privileges being denied because of inadequate documentation.

We do think it is appropriate for careful scholarly investigations of documentation to be conducted. Questions urgently needing an answer include (1) is there evidence that programs that do not require documentation place their graduates at higher risk for denial of privileges, and is the absence of documentation the reason; (2) is documentation cost effective—is the extra effort involved in documentation balanced by a decrease in effort in obtaining privileges; and (3) are there demonstrable educational benefits to documentation?

Until these and other critical questions are answered, documentation should remain an investigative tool, and residencies should disclose to applicants their policy on documentation. We hope this issue will be the subject of more careful discussion before we proceed further down a potentially fruitless bureaucratic path.

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The preceding letter was referred to Drs. Schneeweiss, et al, who respond as follows:

We were hopeful that our article on the University of Washington Affiliated Residency Network documentation system would contribute to the debate regarding this important subject.[1] Franks and Naumberg have raised some important issues concerning the practicality of documentation for busy residents, the absence of evidence that it is indeed necessary for privileges, and the possibilty that documentation numbers may be used to deny privileges.

The log-card approach that emphasizes the documentation of only a limited number of items is well accepted by the residents in our network. Over the past several years more than 75 percent of the residents graduating from the seven affiliated civilian residency programs have participated in the voluntary log-card system (82 percent for the 1987 graduates). Perhaps the most compelling reason for this acceptance is the strong faculty support for this method of documentation to support future hospital privilege application.[2] We are not aware of any undue anxiety engendered by our recommendation to log experiences in training.

What should be documented, and how helpful is this type of documentation to obtain privileges?

The residents in this study focused on recording their obstetrics, critical care, and surgical experiences. Indeed, these are the areas most likely to be a source of contention in applying for hospital privileges. In our experience the availability of the log data has been helpful to graduates seeking privileges in these areas, not a handicap. Contrary to the University of Rochester experience, graduates of the Pacific Northwest programs strongly endorse the need for documentation to support applications for hospital privileges. As noted in the article, 50 percent of the graduate respondents used their documentation to apply for privileges, and 47 percent indicated that their hospitals now require documentation. It is possible that graduates from the Rochester program reflect the trend for family physicians in the northeastern United States not to seek contentious obstetric, critical care, or surgical privileges. Parenthetically, several graduates from the University of Washington program who did not keep log cards later returned to review the University Hospital Labor and Delivery or the Coronary Care Unit logs to collect retroactively the information neces-

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sary to support their application for those privileges.

Admittedly, this study does not answer the question, whether privileges were ever denied because of the absence of documentation, nor does it provide the final word on what should be documented. In our opinion, however, it is reasonable to encourage residents to keep a record of their experiences in selected critical areas and for faculty to facilitate that process. Maybe the list of items recommended for documentation could be even more circumscribed than the one adopted by our network; local and regional needs should provide some guidance in this regard.

Certainly the log cards rely on a self-report system. In our network, the cards submitted for entry must carry the patient's name or number. It is therefore always possible to conduct a record audit, which is a deterrant to cheating. However, we do not consider cheating to be a problem. The consistency of the frequencies with which the items are recorded by different residents within our programs provides face validity to the data and the method. Interim reports, monitored by faculty and residents, help identify potential in-training needs. The numbers recorded are helpful in providing both faculty and residents with realistic expectations as to the experiences, and by extension, the limits, generally available in the program. We fully agree with the need to acknowledge one's own limits and believe that documentation of experiences can only support this.

The log-card method is only one way to achieve the goal of a practical, cost-effective documentation system. The direct and indirect costs of our log system are estimated to be $50 per resident per year.[2] We hope that our experience will assist those programs seeking a more streamlined and practical aproach to this issue.

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SCREENING SIGMOIDOSCOPY

To the Editor:

Dr. Frame's nihilism on screening sigmoidoscopy as on yearly checkups (*Frame PS: Screening flexible sigmoidoscopy: Is it worthwhile? An opposing view. J Fam Pract 1987; 25: 604–607*) is unjustifiable to an epidemiologist and practicing family physician like myself, primarily because of the assumption that the sum of the measurable parts equals the total value. Not true, as any provider of comprehensive and continuing care should know. Managers of cartels (health maintenance organizations) find Frame's views financially to their interest in the short run even if not in many patients' best interest in the long run. Individuals can choose for themselves in a system such as "health pay," a system preferred by free-market economist Milton Friedman.[1]

The potential sensitivity of screening sigmoidoscopy is understated by Dr. Rodney (*Rodney Wm M: Screening flexible sigmoidoscopy: Is it worthwhile? An affirmative view. J Fam Pract 1987; 25:601–604*). Of my own 65-cm sigmoidoscopic examinations, over 80 percent reach into the ascending colon when there is no prior laparotomy. These depths were confirmed by audiovideotape, metal detector, and especially by 360-degree rotation after more than 50-cm insertion (usually the full 70 cm of the WA Videosigmoidoscope). At $200 per examination every five years after

the age of 40 years, screening colonoscopy is more cost effective than current breast or uterus cancer screening. More important, when integrated with the personal physician's care of the whole patient, such as eating and emotional adjustments important to care of irritable bowel syndrome, diverticulitis, colitis, hypercholesterolemia, and so on, screening sigmoidoscopy gives a total value incomparably better than isolated testing, in much the same way as a whole car is worth more than its unassembled parts.

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

Dr. Howard Long, in his letter, states that he is able to reach the ascending colon in over 80 percent of his flexible sigmoidoscopies done with a 65-cm sigmoidoscope. This is a revoluntionary and useful technique if indeed his assertion is true. One of the characteristics of a valid or true technique is that it should be reproducible by other persons. To my knowledge, no other physician, be he endoscopist or family physician, has claimed results like those described by Dr. Long. Dr. Long's challenge is to demonstrate that other physicians can achieve the same sigmoidoscopic results that he claims to be achieving.

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

There is a great deal of controversy over the issue of insertion depth (ie, centimeters of endoscope inserted into the body) vs anatomical depth (ie, the amount of intestine actually examined). Lehman et al[1] attached metallic clips at the point of maximal insertion depth. These clips were then located radiographically and an anatomic depth was determined. All readers of these data can agree that any one insertion depth produces an extremely variable anatomical depth. Some have used these data to suggest that the most likely anatomical depth reached by 35 to 55 cm is somewhere in the sigmoid. Generally autopsy studies suggest that the sigmoid describes the distal 32 cm of the human intestine. Therefore, insertion depths beyond 32 cm should usually enter the descending colon. Data from Lehman et al indicated that such was not the case.

Nevertheless, the Lehman et al data represented examinations performed by physicians in training at a tertiary care center. It has been my observation that family physicians continue to improve their endoscopic skills in practice.[2] Therefore, at somewhere between 20 and 100 procedures, I expect that family physicians are routinely reaching the descending colon. A substantial number of procedures probably do reach into the transverse colon as well. I have personally experienced reaching the cecum within 55 cm of insertion depth. Although this case was a surgically shortened colon, I have had other experiences in reaching the ascending colon at 65 to 70 cm. These experiences represent a small number of cases, which partially verify Dr. Long's observation. Family physicians must do the research to prove that their endoscopic skills indeed provide examinations to the extent that Dr. Long suggests. As described by Dervin, most family physicians in practice will probably use longer colonoscopes (105 cm to 180 cm).[3]

Dr. Long is correct in stating that flexible sigmoidoscopy provides benefits in addition to screening for cancer. In our practice it has been extremely valuable in the diagnosis and management of many gastrointestinal complaints, including, but not limited to, diverticulosis, infectious colitis, inflammatory bowel disease, hemorrhoids, irritable bowel syndrome, and others. Furthermore, there are patient education and physician self-advancement benefits, which I have described in other articles.[4-6]

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STUDY OF SMOKING CESSATION THERAPY

To the Editor:

Regarding the article by Allen F. Shaughnessy, Robert E. Davis, and C. Eugene Reeder, "Nicotine Chewing Gum: Effectiveness and the Influence of Patient Education in a Family Practice" *(J Fam Pract 1987; 25:266–269),* I particularly like that the study was set up to simulate the manner in which patients might come into a family practice setting. I feel, however, that to better evaluate the hypothesis on the effectiveness of family practice setting put forth by the authors, the control group should be further broken down as follows: (1) patients receiving counseling but no gum, and (2) patients receiving no counseling and no gum. With this type of setup in addition to the first two groups used by the experimenters, the effects of the interaction of counseling and nicotine gum on smoking cessation can be assessed more accurately.

In analyzing the difference in means of the cessation rates, the authors of the study used analysis of variance. I believe this statistical model is not appropriate for the type of data used in this study. Analysis of variance assumes an experimental model with a normal distribution of the effect variable, which was not true for this study. I feel a more appropriate statistical tool would have been the chi-square, which, incidentally, was used to analyze the significance of the side effects.

The results of the treatment part of this study are consistent with previous studies of this subject. To draw any definite conclusions on the effectiveness of family practice counseling, however, I feel that the study should be repeated in a similar setting with the additions suggested.

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The preceding letter was referred to Drs. Shaughnessy, Davis, and Reeder, who respond as follows:

We appreciate the comments of Ms. Blaise concerning the research design of our project. Her suggestion to further subdivide the control group is interesting, though the criterion for our control group (group C) was smokers who expressed no desire to stop smoking at the onset of the study. Thus they would not be likely candidates for smoking cessation counseling. Since counseling alone (ie, smoking cessation classes) is not usually provided in family practice offices, our goal was to measure the effectiveness of a treatment modality readily available to family medicine patients, nicotine chewing gum.

As to the question of the appropriateness of the statistical analysis, we respond by further explanation. The hypothesis of equal proportions was tested on the mean differences in smoking cessation before and after the interventions for the three groups simultaneously. An assumption that the mean differences in proportions would tend to be normally distributed was made, and analysis of variance was used to evaluate the hypothesis of equal mean differences. This was not clearly stated in the manuscript and we apologize. As no significant differences were detected using the analysis of variance approach, one is not likely to find an effect when nonparametric statistics are used. An analysis of the data in Table 2 using the chi square statistic also supports our findings ($\chi^2 = 1.49$ for all subjects and $\chi^2 = 0.40$ for subjects completing the study).

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