

LETTERS TO THE EDITOR

MEDICAL STUDENT TEACHING AND FAMILY PHYSICIANS' USE OF TIME

To the Editor:

It is nice that Dr Vinson has "formally" looked into the effects that teaching medical students and residents have on the teaching practice (Vinson DC, Paden C, Devera-Sales A. *Impact of medical student teaching on family physicians' use of time. J Fam Pract* 1996; 42:243-9). There is little question that this is time-consuming and decreases productivity. As Vinson points out, one must keep this in mind in contemplating using a practice for teaching purposes.

It has also been our observation that the amount of time taken and the productivity decreased are inversely proportional to the student's experience and training. That is, a resident takes up much less time than a student.

There are also some strong positives to consider from a productivity and time point of view—teachers themselves learn a lot, particularly from some residents. This happens not only because of the questions that are asked, but also from the answers that are given by both sides. That is, we learn significantly from each other.

There is another block of time that also has to be considered: after office hours. One must go over the day's clinical encounters with the student or the resident without patients or staff. This takes time but is probably the most important

part of the learning experience for both sides.

*Eugene Guazzo, MD
Maryland Infirmary
Chaptico, Maryland*

To the Editor:

Vinson et al have made an important contribution to our understanding of the time involved with teaching medical students in the office. Their direct observation of 22 private family practice preceptors and 12 academic family physicians provides more compelling data than previous studies that relied on self-reporting. Like the authors, most readers will probably conclude from this study that teaching students in the office requires extra time and may decrease productivity.

We believe that the results of the 12 academic family physicians are the more important data in the study, and for them, the students actually saved time (6 minutes), a difference that was not statistically significant. These physicians regularly have students in the office and know how to use them efficiently through active learning, whereas private physicians have one or two students per year and rely more on passive observation. The academic physicians have skills that should be shared with private physician preceptors. One half of the physicians actually saw more patients when a student was present!

Studies that document the present situation—ie, medical student teaching in the office requires extra time, adds to costs, and decreases productivity—may be less useful than stud-

ies that demonstrate cost-efficient models of medical student teaching. More funding for medical student education is unlikely, and office settings in a competitive managed care market are not likely to accept decreased productivity as a result of medical student teaching. Medical students can be useful to an office practice if managed appropriately.

*Joseph E. Scherger, MD, MPH
Family Practice and
Primary Care Education
Sharp HealthCare
San Diego, California*

*William C. Fowkes, MD
Division of Family and
Community Medicine
Stanford University School of
Medicine
Stanford, California*

To the Editor:

The article by Vinson, Pader, and Devera-Sales was interesting because it reminded me of some of the problems we faced in the 1960s and 1970s. When the first department of family medicine in Israel was founded in 1968, we required 1 month's clinical clerkship for all 120 senior medical students. Every student was assigned to a community family physician, who soon found out about the extra work and time required to deal with patients and students. Dean A. deVries asked for data to substantiate this. With the help of a management consultant, we found that the workday of a community family physician was increased by 1 to 2 hours for every full day a student spent in the practice. This compares to 52 minutes extra found by Vinson et al.

The other details mentioned in the article correspond closely to what we found, too. We went one step further, however, which might be important to current chairmen

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when negotiating with deans. Dean deVries supplied the equivalent of one extra faculty position, which was used by distributing the money to the community teaching physicians on the basis of the equivalent of 1-1/2 hour's salary for every full day a medical student spent in their practice. It was not a large sum of money, but as it was accompanied by a letter of thanks for their services, it was very well received. We do not know if the system is still in effect today.

*Jack H. Medalie, MD, MPH
Department of Family Medicine
Research Division
Case Western Reserve University
Cleveland, Ohio*

The preceding letters were referred to Drs Vinson and Devera-Sales and Ms Paden, who respond as follows:

We agree with Dr Guazzo that teaching a resident would probably take much less time than teaching a medical student. Our focus was on the latter, and resident teaching in private office settings could be explored further. We also agree that time spent with the student after patients and office staff have gone home is important, and this time was included in our data collection.

Dr Scherger and Dr Fowkes raise interesting issues. They note that academic physicians' productivity does not decrease when a medical student is working with them, but as we noted, it is less to start with (2.3 patients per hour for academic physicians vs 3.9 for private practitioners), a difference we speculated might have been present because "the academic clinic is geared for lower patient-care productivity to allow time for teaching" since students are present more often than not. On the other hand, eight of the 22 private practitioners we observed saw more patients per hour with a student than without. Although this

may be due to random variation or other factors, it supports doing further study of physicians who perceive an increase in productivity when a student is present. When conducted, such studies should also pay attention to the quality of education and the quality of patient care.

Dr Medalie's arrangement with his dean is worth emulating. Whether more funding for medical student education is likely or, as Drs Scherger and Fowkes maintain, not, the funding currently available should follow medical education as it moves to community settings.

*Daniel C. Vinson, MD
Carrie Paden
Amelia Devera-Sales, MD
Department of Family and
Community Medicine
University of Missouri-Columbia
Columbia, Missouri*

PREDICTING SINUSITIS

To the Editor:

I agree with Hickner¹ in his analysis of predicting acute maxillary sinusitis. The original work of Williams and colleagues² determined that the overall clinical impression was a more accurate predictor of sinusitis than any single finding, and this impression performed equally as well as a more complicated logistic regression model.

A key feature of the study by Williams et al was the decision to stratify patients according to the clinician's impression of the probability of sinusitis. A three-tiered standard of "high probability," "intermediate probability," and "low probability" was employed to estimate this likelihood. Using this scheme, patients in a high probability group were found to have documented sinusitis in 74% of cases (likelihood ratio [LR]=4.7). Patients in the intermediate probability group had sinusitis in 46% of cases (LR=1.4), while the low probability group had

sinusitis in 20% of cases (LR=0.4).

The three-tiered classification resembles what many physicians in practice do intuitively. In some instances, the diagnosis of sinusitis is apparent and treatment is prescribed with confidence. In other cases, the findings are less clear: an intermediate probability situation in which the clinician must decide whether further diagnostic testing, empiric treatment, or no treatment is preferable. The data from the study of Williams and colleagues suggest that in this group, we may be "treating two patients with antibiotics to benefit one."

Given the improvement in the accuracy of diagnosing sinusitis using the three-tiered classification, I concur with Dr Hickner's interpretation of the study by Hansen and co-workers.³ The erythrocyte sedimentation rate and C-reactive protein do not have a meaningful impact on the diagnosis of sinusitis. Physicians should be advised that treating empirically is appropriate, especially when the clinical evidence for sinusitis is strong.

*David R. Little, MD, MS
Department of Family Medicine
Wright State University
School of Medicine
Dayton, Ohio*

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Paul A. Nutting, MD, MSPH
JFP Editorial Office
1650 Pierce St
Denver, CO 80214
Tel: (303) 202-1540
Fax: (303) 202-1539
E-mail: paul.nutting@uchsc.edu

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ENDOCERVICAL CELLS ON PAP SMEARS

To the Editor:

This letter is prompted by Dr Lieu's article in the April issue (*Lieu D. The Papanicolaou smear: its value and limitations. J Fam Pract* 1996; 42:391-9).

When I was last involved with the Papanicolaou (Pap) smear, the results would, on occasion, come back with the notation that there were "no endocervical cells seen." Then the rest of the report would continue to note non-evidence of cancer, including a number rating.

It would seem that the laboratory should have stopped after the line that indicated "no endocervical cells seen," and a note should have been added to "prepare new slides with endocervical cells."

Of course, the slides sent in should indicate where the cells were scraped from. If cells other than from the endocervix were scraped, then the laboratory should continue their evaluation.

Robert Hawkins, MD
Santa Barbara, California

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

It is controversial whether the absence of endocervical cells in a Pap smear when they are expected to be present, such as in a premenopausal woman with a cervix, makes the smear inadequate. The presence of endocervical cells would imply sampling of the transformation zone, where most lesions are known to occur. In a reference book widely used by pathologists who report Pap smears, Kurman and Solomon¹ state that the absence of endocervical cells makes the smear satisfactory for evaluation but limited, rather than unsatisfactory. An endocervical sample may be difficult to obtain owing to such factors as age, pregnancy, and previous therapy. Thus, the clinician is the ultimate judge of specimen adequacy because he or she must correlate the cytology report with clinical factors.

In a study of biopsy-proven dysplasias, Sidawy et al² found the same correlation rate between cytologic testing and biopsy in Pap smears with endocervical cells and those without endocervical cells. They concluded that the absence of endocervical cells on a Pap smear should be documented but that it is not an indication to call a smear unsatisfactory. Other authors have reached different conclusions. Elias³ and Voojs⁴ and their co-workers found significantly more epithelial abnormalities in smears with endocervical cells than those without endocervical cells. On the other

hand, Kivlahan and Ingram⁵ did not find an increased incidence of cervical intraepithelial neoplasia (CIN) on second smears in women whose initial smears lacked endocervical cells. Mitchell and Medley⁶ did not find an increased rate of CIN in longitudinal studies in women whose smears lacked endocervical cells. Thus, the current recommendation under the Bethesda System is to regard smears that are expected to have endocervical cells but do not as satisfactory but limited, rather than unsatisfactory.

David Lieu, MD
Department of Pathology
Merrithew Memorial Hospital
Martinez, California

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