Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints might prevent this in some cases. The problem is compounded in a bimonthly journal where continuity of comment and redress are difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

On-Site Colposcopy Services

To the Editor: As the physician-educator who installed the colposcopy service described by Prislin et al,[1] I believe it might serve the readership to remember that procedures are part of family medicine, but family medicine is more than the sum of its procedures.[2]

The study from California ignores several important confounding issues.[3,4] At the study location, which is a community health center, most of the patients are poor and many do not speak English. Even the English-speaking patients have a substantial language barrier. This language barrier adds to the difficulty in explaining risk versus benefit of any therapeutic procedure.[5] The snapshot of compliance by appearing for the examination ignores the more complicated continuity issue of preventing cancer within the context of the community and the family. Currently, there is no dollar value that can be ascribed to this activity.

The physician-patient relationship, which is strengthened through the continuity of such activities, is not mentioned. In my experiences at that particular community health center, continuity practice was rare. It does not surprise me, therefore, that one discontinuous system is as good as, if not better than, another discontinuous system. An advanced curriculum in such procedural techniques as colposcopy or diagnostic obstetric ultrasound simply provided a teaching opportunity for the advancement of the physician-patient relationship. Additionally, colposcopy provided an opportunity for family practice residents to acquire a more sophisticated level of cognitive skill through the psychomotor act of the procedure. These procedural skills provided physician trainees the opportunity to take these skills into their own private practice. Is this worth something?

The residency environment is notoriously inefficient. Accordingly, cost-benefit analyses should take into account that residencies routinely consume financial resources at a rate far greater than private practice. Simultaneously residency environments generate collections at a rate of 40 cents on each dollar charged.

One reason we purchased colposcopy equipment for the Community Clinic of Orange County was that it allowed us to see all patients regardless of their ability to pay. Before that time it was not possible to refer easily a patient who had no means of support to a consultant colleague for procedural services. Worse yet, some of our patients were not citizens. That particular family practice center was established with the purpose of serving all members of the community regardless of the ability to pay, and at that time (1987) on-site colposcopy services made it possible.[6] The installation of these procedures was not an attempt to get everyone to do everything; it was a successful experiment to improve the probability of a continuous physician-patient relationship in the difficult environment of many non-English-speaking poor patients.

Shelf life of equipment is underestimated. One of my colposcopes has been in service for more than 12 years and still works extremely well. In practice this equipment paid for itself in the first year. Amortization schedules, which give no credit for the long life of the equipment used under normal conditions, undervalue the revenue attributable to these procedures. In practice special training or additional staff were not necessary. Standard office nursing support comfortably included this procedure into the office routine.

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To the Editor: I was intrigued when I read both the article by Prislin and colleagues[1] describing on-site colposcopy services in a family practice residency and the accompanying editorial by Thomas Norris.[2] Dr. Norris's comments are interesting because he questions incorporating procedural activities into the clinical domain of family practice, the availability of these procedures, and the potential impact of using these procedures, but he never once questions the actual procedure. The elephant in the room is that perhaps family physicians should not do these procedures but let our