To the Editor: We readily agree there are numerous advantages for family physicians *and* their patients when family physicians have the ability to perform flexible sigmoidoscopy (FFS).

Dr. Glinka expressed concern that we implied it is acceptable for family physicians to go to a 1-day seminar and then start doing FFS on their own. Apparently he is referring to our sentence that states "numerous seminars . . . can *help* physicians get a good preparation for starting FFS in their office."(p 192) We believe the word *help* (highlighted here) is critical to a precise interpretation of the sentence. We believe many of the seminars offered around the country would be of benefit to the family physician starting FFS (many of which are more than 1 day), but we do not recommend that these seminars be the only preparation.

However, as we stated in the article, back when there were few if any willing preceptors, a number of us combined self study (articles, discussion, intermittent supervision) and control with simultaneous rigid and flexible instrumentation in informed and willing patients to learn the procedure well.

Now there are many more opportunities to receive direct supervision, and we strongly encourage all family physicians to take advantage of these preceptors and learn the procedure for themselves *and* their patients. We also recommend initial preparation prior to supervision to include seminar attendance and review of textbooks and articles.

Today, many family practice residents have the distinct advantage of learning FFS during their residency. Additional supervision, seminar attendance, self study, peer discussion, and videotape review would further enhance one's depth of knowledge on the procedure.

The situation in which preceptors are still not available for the family physician who desires to learn flexible sigmoidoscopy is somewhat more complicated. We suggest that if the physician is adept at procedures in general and patients are fully informed and if control is maintained according to the current standard of such a practice (i.e., rigid sigmoidoscopy), then the physician may consider learning the procedure using the previously described educational techniques.

Our sincere hope is that subspecialists will unite with family physicians in an effort to provide our patients with the best and largest variety of services available. Our patients are much better served when we all work together.

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Consultation/Referral Patterns

To the Editor: In Dr. Heiligman's editorial response[1] to our article on family physician consultation/referral patterns,[2] he makes reference to the ongoing debate in internal medicine circles about the appropriate role of the general internist. He suggests three categories of adult patients he believes are best referred to a general internist. These are:

1. "Patients who have multiple medical illnesses involving several organ systems, all of which are important and interrelated." In such patients, he believes that "the general internist's impartiality may be an advantage in looking at the total internal medicine picture."
2. "Patients whose presenting complaints are nebulous or not easily categorized by organ system." Again, he cites the benefits that "an unbiased generalist" would lend.
3. "Patients in whom the family physician identifies a leading medical problem, possibly in a particular subspecialty, but in whom a more measured and less aggressive approach is desired." In this situation, he suggests that the "generalist's cognitive skills may be more helpful than the subspecialist's procedural imperative."

Dr. Heiligman also suggests that referral to a general internist may well be advantageous "in complicated cases [where] three or four individual referrals to different subspecialists may be necessary . . . ." He correctly notes that this is "confusing for the patient and his/her family . . . [and] quite expensive."

We want to point out that in our article[2] we did not suggest the termination of general internal medicine training programs. We, too, believe that there are situations in which referral to a general internist rather than a subspecialist(s) is appropriate. We agree that the general internist can be very

valuable in managing patients with multiple medical illnesses.

We urge caution with respect to patients in his category two, those presenting with "nebulous" complaints or "not easily categorized by organ system." These patients often suffer from a somatoform disorder.[3] Family dynamic issues play a significant role in these situations.[4] This is not to say that the physician can attribute such problems to a psychosomatic disorder without thoughtful consideration and appropriate evaluation. Physicians in all disciplines, however, have fostered somatoform disorders in some of their patients because they did not recognize the characteristics in these patients and families. Family practice residencies require behavioral science training, and residents obtain fairly extensive education in the field.[5(p 25-6)] This is not true of internal medicine training programs.[5(p 42-3)] The family physician also enjoys the added advantage of caring for the entire family. We therefore believe the residency-trained family physician is better equipped to recognize, appropriately evaluate, and manage such patients in an efficient, cost-effective manner.

We agree that an option for using a general internist exists in the care of patients Dr. Heiligman describes in category three. We would note, however, that family physicians and other generalists are quite good at choosing between aggressive and less aggressive subspecialists, depending upon the approach indicated.

Regarding the patient for whom three or four different subspecialists might be required, we agree that it may be more prudent to consult a broadly trained, well-versed consultant. Too many physicians can be confusing to the patient. When several consultants are required, we believe it is extremely important for the family physician to serve as the "captain of the ship" in directing the evaluation and management and to serve as the primary communicator, educator, and advocate for the patient and family.

General internists should continue to be trained. Those who go on to practice general internal medicine help fill the need in primary care. As noted in our article, however, the majority of internists subspecialize[6] adding to an increasing overabundance of subspecialists and doing little to help the primary care shortage. On the other hand, of the 21,816 graduates of family practice residencies, 93.5 percent are providing direct patient care.[7] In this time of need for primary care physicians, doesn't it make sense to train physicians who will practice primary care medicine?

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Adoption

To the Editor: I am responding to the two-part article[1-2] on adoption (January-March 1988 and April-June 1988) and to the letter[3] on adoption (July-September 1988). I applaud the editorial decision to deal with this often forgotten and ignored issue that has a major impact on family life, and I was pleased with the overall content of the articles.

As a family physician and adoptee, I believe that the manner in which physicians deal with the issue of adoption and with the persons involved in the adoption triad (birthparents, adoptive parents, and adoptees) can set the stage for improved adjustment to the realities of identity and development that arise for each of the parties. The Melinas have stated the point very well on the need for sensitivity and concern on the part of physicians dealing with these matters. However, being well-meaning is not enough. Physicians need to be knowledgeable about expected emotional reactions by triad members, who may be emotionally labile depending on the maturity level and stage of resolution of the different issues involving them. Providing emotional