Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints may prevent this in some cases. The problem is compounded in the case of a quarterly journal where continuity of comment and redress is difficult to achieve. When the redress appears 3 months after the comment, 6 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.

Postpartum Pap Smear

To the Editor: The article by Weiss, et al. in the January–March 1989 issue on "The Postpartum Papanicolaou Smear" raised important questions but did not answer them. Certainly, the conclusions that the authors drew were not fully justified.

I do not question their findings that the rate of "abnormal" Pap smears in the postpartum period was higher than that at the beginning of prenatal care. What the authors did not determine, however, was whether these changes were due to the passage of time or due to the intervening pregnancy and delivery. What would the findings have been if a control group of women, with normal Pap tests and routine screening, had repeat Pap smears in 6–9 months rather than 1 year? Would that number of abnormal Pap smears have increased at an equal rate? Or, if no treatment was undertaken of those patients with abnormal postpartum Pap smears in the study group, but whose Pap smears were repeated at a time 1 year following the initial Pap, would the abnormal findings have gone back to normal again?

Without such additional information, the following possible conclusions can be drawn from this article's findings: (1) pregnancy itself causes the development of abnormalities of the Pap smear but we do not know whether these abnormalities are transient, and (2) the *rate of abnormal Pap smears in all women is increasing* so rapidly with time that routine Pap screening should be repeated every 6–9 months rather than every year. If the first conclusion is accepted, it indicates that further research must be done to describe the natural history of the Pap smear with respect to pregnancy. To accept and implement the second conclusions would have a tremendous economic impact with dubious justification. The study does not support the authors' conclusion that repeating Pap tests at the postpartum visit is necessary to reduce morbidity and mortality from cervical neoplasia.

We family physicians frequently bemoan the way physicians and other specialties often rush to put into practice new diagnostic and therapeutic techniques before their justification has been soundly established (e.g., balloon angioplasty, dual photon densitometry, "once a C-section always a C-section"). I hope that our specialty can continue to hold out for unequivocal proof of the value of new "standards of care" before we saddle ourselves and the public with them.

Conrad Lindes, M.D.
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The above letter was referred to the authors who offer the following reply.

To the Editor: Dr. Lindes states that although the rate of abnormal Pap smears among our patients was higher at the postpartum visit than it was at the prenatal visit, the cause of this apparent increase in the rate of cervical dysplasia was not clear. We agree! There are many possible explanations for the high rate of Pap smear "conversions," some of which were discussed in our article.

The uncertainty about why so many postpartum Pap smears were abnormal should not, however, dissuade physicians from continuing the long-standing practice of obtaining Pap smears at both prenatal and postpartum visits, especially in patient populations with demographics similar to ours. With dysplasia occurring in 1 out of every 20 postpartum Pap smears, we believe that the benefits of screening, at least in terms of yield, is self-evident. This is the case regardless of the reason(s) why the rate abnormal Pap smears develop.

Dr. Lindes also suggests that the abnormal postpartum Pap smears in our study might have been transient reversible abnormalities that were somehow related to pregnancy. Previous studies, cited in our report, indicate that abnormal cervical cytology does not progress during pregnancy, making it also unlikely that new cytologic abnormalities would appear de novo simply because of pregnancy. In addition, half of the postpartum Pap smear abnormalities in our study were either moderate or severe squamous dysplasia – not the types of abnormalities one would expect to resolve spontaneously. Therefore, we continue to recommend that physicians in our practice obtain routine postpartum Pap smears and that they institute appropriate evaluation and therapy when abnormalities are found.

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Editorial: Any More Cordials to the Drooping Spirit?

To the Editor: I tore the essay, "Any More Cordials to the Drooping Spirit? Professional Ethics, 1847–1989," out of the *Journal of the American Board of Family Practice*, 1989; 2:212-5, and it has been sitting on my desk for some weeks while I debated whether to write to you about it. Most of it is great stuff, vintage Gayle Stephens, addressing some of the subtle but potent interpersonal issues we deal with in "real world" patient care. One paragraph

stood out like a solitary dandelion on a country club lawn, and I hope you'll forgive me for challenging it:

> Few human relationships, expert or otherwise, can tolerate that much honesty. . . . We do not tell patients when we find them tedious or boring; how trivial we find many of their complaints; how we dread their headaches, backaches, fatigue states, and nerves; how repulsed we are by their "refractory" obesity; how inane we think it is to worry about cholesterol when one has not lost weight, exercised, and given up smoking cigarettes; how we hate it when they do not comply with our recommendations; how we resent their denials, misrepresentations, and withholding of information. I find it hard to confess here that I have such feelings, and I have no intention of sharing them with my patients.

It seems to me that recognizing and adapting to human imperfection is part of being a family physician. Dr. Stephens is correct in saying that we neither do nor should express hostile feelings toward patients, but one reason for having "behaviorists" around our residency programs is to help our young colleagues learn to face their feelings openly and not get "uptight" when human beings act like human beings. The alternatives, both unsatisfactory, are burnout and cynicism.

Ian McWhinney helped me with this issue a long time ago when he suggested that "problem patients" cease to be "problems" when we look at the person behind the behavior, become intellectually interested in them, and seek to understand the internal dynamics of their behavior. This approach has worked for me in terms of helping patients and also relieving my internal stress.

My one small contribution to the medical literature in this area appears in *J Fam Pract* 1986; 23:431. In working with residents I'm more inclined to fall back on aphorisms as conversation starters. Here are a few that might have relevance:

> One of the greatest honors we can confer on other people is to see them as they are; to recognize not only that they exist but that they exist in specific ways and have specific realities.
>
> – Shiva Naipaul

> We yearn for the precision of science but sit amongst the mess and fuzz of humanity.
>
> – D. G. Wilson (*J Roy Soc Med* 1988;81:3)

> The physician needs a clear head and a kind heart; his work is arduous and complex, requiring the exercise of the very highest faculties of the mind while constantly appealing to the emotions and inner feelings.
>
> – Sir William Osler

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Editor's Comment

Dr. Gillette is not the first to take umbrage at my "dandelion," although his remonstrance is gentle and consistent with his counsel and the flavor of his aphorisms. Another person accused me of betraying myself and my other writings through this confession of negative feelings about patients. It was as if I have created an expectation of total understanding and benevolence in physician-patient relationships that I cannot violate now.

The truth is, I have always been a reactive person with hard edges that sometimes become exposed. I deny cynicism, however, and I've never burned out in patient care; but I do become confrontational at times.

The paragraph in question was not intended to be mainly about me as an individual, but to express what I believe to be generic feelings among physicians. I used myself in the last sentence as a rhetorical device in order to identify with readers to show that I am a fellow-traveler and not merely a critic.

Dr. Gillette is quite correct about our need to teach and practice tolerance, patience, and forbearance towards our patients. It was Carl Rogers who first used "unconditional positive regard" as the proper clinical attitudes, which seem to be close to the Biblical notion of grace. I remember a long conversation with a medical corpsman when I was a 25-year-old first lieutenant in the medical corps about whether "acceptance" is a higher and better virtue than "forgiveness." (I haven't thought about that in a long time; perhaps, he was right.)

On the other hand, I believe that family physicians, more than most physicians, deal with intimacy; by that very fact, they also have more to do with the dark side of human emotions – their own as well as those of their patients. Merely to hide this, or gloss it over with professional style, (which I know Dr. Gillette has not said) can be demeaning to patients and probably ultimately corrupting to physicians. Then, I become upset when another person does not take my anger seriously, like telephone operators used to do. I resent being the object of programmed responses intended to blunt my feelings. Patients must feel the same when physicians reassure vacuously, or give them platitudes.

I have digressed, but let me add one more thought to show that I am accepting the reproach. Leston Havens, in his newest book about psychotherapy, *Making Contact*, deals with the language of therapy and has a section on "performative statements." These are statements of the type that create states of being. "I pronounce you husband and wife," or "I christen thee the *SS America*," creates the state of marriage and being named. Havens sometimes uses "I admire this or that about you," which creates in the patient the state of being admired. He finds this useful in some circumstances.

Thanks for writing. It was an act of charity.

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References

1. Havens L. Making contact: uses of language in psychotherapy. Cambridge, MA: Harvard University Press 1986: 141-159.

NSAIDs

To the Editor: The article on nonsteroidal drugs (JABFP 1989; 4:257-71) was a good outline. However, I did want