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.

Procedures in Family Practice

To the Editor: It might be in the eye of the beholder. A family physician ethicist who looks at procedures reflects on ethical issues. The family physician who is procedurally oriented views the development of new primary diagnostic and therapeutic procedures as a logical extension of the domain. The family physician ethicist reflects on the appropriateness of incorporating a new procedure into practice. At a time when other disciplines are expanding their turfs, it is important that family practice not only "be proud of what is unique" but also address what is common in ambulatory primary care. Long before there was a specialty board for family practice, general practitioners were performing rigid sigmoidoscopies, uterine dilation and curettages, and cervical conizations. As the discipline has advanced, more refined office-based approaches have been developed to examine and treat these areas.

In their recent article "Family Physicians as Proceduralists: Striking a Balance" (JABFP 1995; 8:58-61), Brody and Alexander define high-quality practice as a "less costly and often more elegant low-tech, high-touch approach." Examining orifices, however, has always been part of the field of family practice. If a person has ear pain, it is appropriate to use an otoscope to examine the ear. I believe that when symptoms direct or guidelines recommend, other apertures should be appropriately evaluated. If accepted clinical guidelines recommend a flexible sigmoidoscopic examination every 5 years after the age of 50 years or a colposcopic examination to follow up an abnormal Papanicolaou smear, it is appropriate for a trained family physician to perform the examination. The primary motivation should be the patient's benefaction. Secondary motivating factors can include the satisfaction from doing procedures or the preferential reimbursement for procedures.

The argument that the physician performing one's own procedures is a form of self-referral is appropriate to consider. In a similar manner, however, physicians recommend comprehensive examinations and return interval visits to monitor chronic disease or to promote health maintenance, which are also self-referrals that can be appropriately made or generated to assist in paying the rent. The issue relates to the medical appropriateness of the procedure or office visit.

In the past, as in the present, procedures have generated more income than have cognitive visits. There are loss leaders, low-ticket and high-ticket items, in all businesses. A physician with a balanced practice will compensate for the disparity. I agree with Brody and Alexander that our specialty can "work to develop more explicit guidelines on how many and what sorts of procedures family physicians must do to be competent." Because failure to diagnose is a frequent malpractice issue for family physicians, it is extremely important to practice according to current guidelines. In addition, family physicians should be involved in the development of guidelines concerning the appropriate indications for procedures. I do not believe, however, that family physicians should only "perfect their eyes, ears, and interpersonal skills" to diagnose patient problems. If family physicians are to provide comprehensive care for patients, they should also be skilled "to use machines," such as the stethoscope, otoscope, sigmoidoscope, and colposcope. The expense for the patient or system will be there whether the personal physician performs the procedure or refers the patient to another physician.

In summary, I believe that it is appropriate for family physicians to be trained in the office-based procedures commonly performed on ambulatory patients. Appropriateness and competence must meet not only the standards of our discipline but of medical practice in general. The primary motivation should be maintaining the well-being of the patient and family.

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To the Editor: I appreciate the thoughtful commentary of Brody and Alexander on family physicians as proceduralists.[1] The authors are exactly right in recognizing the need to strike an ethical balance. I assume their article is meant to focus on "high-tech" procedures, or what I would call bigger procedures, such as colposcopy and sigmoidoscopy. In that regard, I would agree that teachers or practitioners should never overemphasize procedural skills to the neglect of interpersonal or patient care skills. In an effort to place bigger procedures in the appropriate context, however, we should not forget that the smaller, "low-tech" procedures form an integral part of our "high-touch" profession.

As Carmichael[2] points out, procedures such as removing ear wax or trimming toenails are excellent ways of caring for patients. We family physicians are intimate with our patients, and the more skilled we are at touching them, examining them, and doing things for them with little or no discomfort, the more we strengthen the physician-patient bond. Seemingly minor things, such as injecting local anesthetics in a way that minimizes discomfort, can deepen a patient's appreciation of a physician's skills.