with detecting all possible abnormal patients. I hope researchers in family practice will lead obstetrical care to a more practical and specific approach to the diagnosis of gestational diabetes.

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### Adoption

*To the Editor:* In the April–June 1988 issue, there is an article entitled "The Physician's Responsibility in Adoption, Part II," written by Carl and Lois Melina. I thought the article was very well written and pertinent.

The issue of informing an individual that he/she has been adopted still seems of great importance to me. I cannot understand why there is such a rush by so many these days to let individuals know that they have been adopted. It seems reasonable to me either to not inform the person or to delay the information until the child is at least 18 and more able to withstand the typical confusion and dismay that such news brings. I know of two cases in which children, who were told at an early age that they were adopted, suffered considerably because of the distrust and wonder that this information caused. Furthermore, unless there is some clearly important information about a person's genetic or other background to relate, I doubt that we should inform someone that he/she has been adopted.

Ignorance can indeed be bliss in some matters.

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### Consultation/Referral Patterns

*To the Editor:* In a recent article, Vogt and Amundson[1] reported the results of their survey of North Central members of the American Academy of Family Physicians about referrals to internal medicine and pediatric generalists versus subspecialists. With regard to internal medicine consultation/referral, they documented a strong preference for referral to subspecialists as opposed to generalists. This was particularly true for residency-trained family physicians.

As a general internist who has taught full time in family practice residencies for the past 9 years, I am somewhat dismayed by these results. The role of the general internist has been widely debated in internal medicine circles. On the one hand, the general internist is viewed as an "adult medicine specialist" who would be better prepared to deliver primary care (in concert with pediatricians and obstetricians) than would the family physician.[2] On the other hand, the general internist is viewed as a diagnostic consultant who would have special and intensive training in the wide variety of technical procedures currently being performed by subspecialists.[3] I have previously participated in this debate and have suggested that there are at least three categories of adult patients who would be best referred to a general internist.[4] These categories are:

1. Patients who have multiple medical illnesses involving several organ systems, all of which are important and interrelated. 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. This is a surprisingly common occurrence and once again benefits from the perspective of an unbiased generalist.
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. The generalist's cognitive skills may be more helpful than the subspecialist's procedural imperative.

There are other advantages of referral to a general internist. In complicated cases, three or four individual referrals to different subspecialists may be necessary to answer all of the family physician's clinical questions. This is difficult and confusing for the patient and his/her family, not to mention quite expensive. No reasonable physician would use several different drugs when one would suffice. Why should the principle be any different when choosing consultants? I suspect that initial referral to a subspecialist (who may feel insecure in evaluating questions outside his/her narrow field) is more likely to result in a pattern of secondary and even tertiary referral, often completely unknown to the originating physician. Such patients frequently become lost in a complex medical system for months at a time, returning to their family physician only after multiple aggressive interventions. This phenomenon resembles Michael Balint's *Collusion of Anonymity*. I believe that an initial referral to a general internist would less likely result in such fiascoes.

The authors correctly identify some of the factors influencing the referral choices of family physicians in

their survey. Family practice residents do have a dearth of role models for the general internist who relates well to family medicine as a specialty and also has a comprehensive internal medicine knowledge base and incisive clinical skills. However, it also appears that the bias against the general internist has become institutionalized. For example, the editorial advisory board of *American Family Physician* (received by all of the respondents in the current survey) consists of 45 physicians and one dentist representing 34 separate clinical disciplines. There are no general internists on this list. Continuing medical education programs for family physicians, while frequently featuring a high proportion of specialist speakers, almost never include a general internist. Is it a wonder that the average practicing family physician is subtly discouraged from regarding the general internist as a valuable resource? Perhaps further research and debate in this area will change these ingrained opinions and bring us back to Sir William Osler's sentiment that "the student of internal medicine cannot be a specialist."

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### Papanicolaou Smear

*To the Editor:* Dr. Crump's clinical essay on the Papanicolaou Smear[1] was a succinct and accurate review of an extremely powerful secondary prevention screening tool used by family physicians. Other key points that relate to understanding the success or failure of Papanicolaou smear screening can be categorized into areas of (1) patients at risk, (2) physician performing the examination, (3) cytology service, and (4) natural history of cervical carcinoma.

All sexually active women[2] are at risk but certain others are at higher risk. In addition to risk factors noted in Dr. Crump's review, one must consider cervical herpes infections[3] and women whose sexual partners have multiple partners.[4] Physicians need to determine the status of these risk factors and adjust the frequency of screening for those at high risk. No studies have examined physicians' adherence to these standards. I have found anecdotal evidence that many physicians do not inquire about social-behavior habits. In addition, multiple studies have shown that those at highest risk for cervical carcinoma are the least likely to seek screenings.[5,6] Physicians need to address this fact as a public health issue and not regard it as a compliance problem outside the confines of one's office practice.

The physician's skill in performing the examination is central to effective screening for cervical carcinoma, but equally critical are patient education, tool selection and adherence to protocol for use of tools, follow-up smears (normal, inadequate, and abnormal), and interaction with the cytology service.

The patient should receive preparation instructions when calling to schedule a Papanicolaou smear. These include:

1. Scheduling the examination during midcycle and avoiding menses.
2. Avoiding vigorous intercourse or douching for 24 hours before the examination.
3. For new patients, having available all previous Papanicolaou smear reports.

It is important to perform the examination during midcycle to avoid contamination of the slide with blood or serosanguinous material of menses, and there are other critical steps that influence reliability and validity of Papanicolaou smears. The American College of Obstetrics and Gynecology[7] has offered a protocol for cell collection that is presented below. Additions from other sources are noted by asterisks.

* 1. Patients seeking the Papanicolaou smear should not douche or engage in vigorous sexual activity before the examination (the usual time limit is 24 hours). The appointment should be scheduled during the midpoint of the cycle.
* 2. Risk factors for cervical carcinoma should be determined (i.e., first intercourse before age 18, multiple sexual partners, partner who has multiple sexual contacts, herpes infection, papilloma virus infection, other sexually transmitted diseases, and previous dysplasia).
3. The vagina and cervix must be visualized with a *nonlubricated* speculum. The Papanicolaou smear must be performed before any other procedure. Identification of the squamocolumnar junction is desirable.
* 4. Vaginal discharge, when present in large amounts, should be carefully removed. *Do not* routinely clean the cervix.
5. Separate the sampling of the endocervix and ectocervix results in the highest rates of detection.
6. The endocervical sample should be taken first via suction bulb, cotton swab (moistened), or cytobrush.
7. The ectocervical sample should be taken next via a scraping tool (e.g., Ayre spatula, extended tip spatula).
* 8. The sample material should be placed on a separate slide in a uniform manner for endocervical and ectocervical samples. The best methods to achieve such slides are counterclockwise movements of the spatula and reverse rolling of the cotton swab or cytobrush, both with moderate pressure.