**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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### References

1. Prislin MD, Dinh T, Giglio M. On-site colposcopy services in a family practice residency clinic: impact on physician test-ordering behavior, patient compliance, and practice revenue generation. J Am Board Fam Pract 1997;10:259-64.
2. Magill MK. Procedures are part of family medicine, but family medicine is not procedures. Fam Med 1997;29:590-2.
3. Rodney WM. The dilemma of required curriculum for emerging technologies in primary care. Fam Med 1997; 29:584-5.
4. Rodney WM. Family practice procedures. J Fam Pract 1995;40:223-4.
5. Rodney WM. Traduttore, traditore (cross-cultural medicine). JAMA 1986; 255:2600-2.
6. Rodney WM, Felmar E, Richards E, Cousin L. Colposcopy and cervical cryotherapy: feasible additions to the primary care physician's office. Postgrad Med 1987;81(8):79-86.

*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

subspecialist colleagues do them. Every question asked by Dr. Norris in his editorial regarding whether family physicians should incorporate procedures into their practice could easily be addressed to our subspecialty colleagues. Many procedures have been incorporated into practice without the benefit of strict cost-effectiveness studies. The question speaks to the role of procedures in medicine as well as family medicine.

I believe a set of criteria should be developed regarding the applicability of procedures, which I would model after Koch's Law—the criteria used in proving an organism is the cause of the disease or lesion. This set of procedural postulates might also be used to determine funding procedural education by limited-resource organizations (American Academy of Family Physicians, American Board of Family Practice, Health Care Financing Administration, etc).

| Koch's Law Postulates | Procedural Postulates[3] |
|---|---|
| (Criteria proving organism is cause of disease or lesion) | (Criteria proving procedure is important for physicians to learn and do) |
| 1. Microorganism in question is regularly found in disease lesions | 1. Procedure is in general use or is thought to go into general use in near future |
| 2. Pure cultures can be obtained from it | 2. Procedure is tested to be valid |
| 3. Pure cultures, when inoculated into susceptible animals, can reproduce the disease or lesions | 3. Residents, when taught procedure through adequate curriculum, can learn indications, complications, and side effects, and can successfully complete the procedure. |
| 4. The organism can be obtained again in pure culture from the inoculated animal | 4. Procedure can be used in the primary care setting to alter behavior, enhance lifestyle, deepen patient-physician bonding, improve compliance, and help preventive medicine strategies, thus reducing morbidity and mortality |

The first three procedural postulates can be relatively presumed. The fourth is the hard one. Toward that aim, I examined whether exercise treadmill tests are capable of altering behavior and I was surprised to find that a positive exercise treadmill test had a positive effect on short-term quit smoking rates.[4] I suspect that a procedure such as colposcopy modifies unprotected sexual intercourse when human papillomavirus or other organisms or changes are found. Whether diverticular disease found upon flexible sigmoidoscopy can encourage a change in diet or behavior has not been studied. The list goes on and on.

I would agree that family physicians have moved beyond needing to prove they can do certain procedures. We know that we can do them and do them well. Now it is time to prove that these procedures have a valid role in modifying behavior or improving morbidity and mortality.

Curiously, no mention is made of whether medical students are more attracted to a residency that offers training in procedures, of parity with our subspecialty colleagues in hospital, of potential savings of time and money, of unavailable subspecialists in truly rural settings, or of maximum benefit to the resident.

I look forward to these interesting times we live in.

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**References**

1. Prislin MD, Dinh T, Giglio M. On-site colposcopy services in a family practice residency clinic: impact on physician test-ordering behavior, patient compliance, and practice revenue generation. J Am Board Fam Pract 1997;10:259-64.
2. Norris T. The role of procedures in family practice: is there a right answer? J Am Board Fam Pract 1997;10:307-8.
3. Scarpinato L. Scarpinato's postulates. Lecture presented at Kansas City Family Practice Residency, University of Missouri, Kansas City, 23 July 1992.
4. Scarpinato L, et al. Smokers reprimanded following a positive ETT have a higher immediate quit smoking rate than those with a negative ETT. Clin Res 1991;34:639A.

**Inpatient Practice and Hospitalists**

*To the Editor:* Having taken the time to study, analyze, and publish the recent report by Stadler et al[1] and the accompanying editorial by Rivo[2] on this important and timely topic, the author, editorialist, and editor are to be chided for not making more of such an opportunity. The related topics of hospital practice, obstetric care, and procedures are critical fault lines in the discipline of family practice as a whole and, even more evidently, between family practice educators and practitioners. As such, they richly deserve, though often elude, careful and balanced analysis.

The authors fall short of their potential by failing to deal with important methodologic, clinical, and data issues. The physician's interest in the topic of hospital care is a likely correlate of the decision to respond to the survey. Acknowledge that this initial bias might be important. Recall bias should also be addressed. It seems to me essential to differentiate hospital-based obstetric care from illness care and to be sure that hospital-based ambulatory procedures are not included in the data. I do not recall a similar data set published in which the median was the only data point acknowledged. Finally, the research conclusion takes a peculiar form: "Inpatient medicine continues to figure prominently in the work of family physicians." How was this operationally defined? What is the null hypothesis? What a priori data manipulations, tests of significance, and so on, were embraced by the researchers to prove or disprove their research question?

Dr. Rivo's commentary is thoughtful and more balanced. Nevertheless, both he and the authors of the original report amply reveal their biases; we are old enough to realize that further studies will have little or no impact on the course of the practice under consideration.

Dr. Stadler and colleagues could have offered a more important and thought-provoking contribution to the