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.

Outpatient Consultation

To the Editor: I am writing in response to the article by Dr. William J. Crump and Ms. Patricia Massengill in the July-September 1988 issue. The authors note only two reports from family medicine residency programs, with the maximum length of data collection from any site reported as 12 months. Although the report does contain one of the largest and longest series of referrals, there is a serious difficulty with the study. The authors have overlooked a substantial number of relevant articles on the subject of referral,[1-7] both overall and within the context of residency programs.

The Glenn study,[1] in particular, addresses a time period (36 months) longer than the 12-month length cited by Crump and Massengill. The studies by Glenn et al.,[1] Hines and Curry,[3] Dolezal et al.,[2] and Lawler[7] report data from residency training programs. The omitted studies also report a broader range of referral rates, from 1.04[2] to 5.30,[3] albeit the latter in a Canadian program.

Although the Crump and Massengill report is a valuable and unique addition to the current literature on referrals, the impact may not be as great as it first appears. Certainly, referrals and consultations are fertile areas for family medicine research.

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References

1. Glenn JK, Hofmeister RW, Neikirk H, Wright H. Continuity of care in the referral process: an analysis of family physicians' expectations of consultants. J Fam Pract 1983; 16:329-34.
2. Dolezal JM, Amundson LH, Sinning NJ, Hoody HJ. PriCare and ambulatory referrals. Cont Educ 1980; 12:84-94.
3. Hines RM, Curry DJ. The consultation process and physician satisfaction: review of referral patterns in three urban family practice units. Can Med Assoc J 1978; 118:1065-73.
4. Moscovice I, Schwartz CW, Shortell SM. Referral patterns of family physicians in an underserved area. J Fam Pract 1979; 9:677-82.
5. Mayer TR. Family practice referral patterns in a health maintenance organization. J Fam Pract 1982; 14:315-9.
6. Pagel J, Wood T. Transport patterns and complications in an isolated Alaska practice. J Fam Pract 1983; 16:957-62.
7. Lawler FH. Referral rates of senior family practice residents in an ambulatory care clinic. J Med Educ 1987; 62:177-82.

The above letter was referred to the authors of the article in question, who offer the following reply:

To the Editor: We sincerely appreciate Dr. Lawler's thoughtful critique of our selection of referenced articles on the subject of referral. Some of these were known to us but excluded, and others were not discovered during our literature review. The latter is a valuable lesson in library science. The Glenn study[1] does in fact include 36 months of data. The Glenn report was based on a residency training site in rural Fulton, Missouri, and excluded information consultations between residents and faculty in various specialties who served as clinic attending physicians. Despite this significant difference from our study, the finding of 1.65 percent was very similar to our consultation rate of 1.4 percent.

The work by Dolezal et al.[2] was entirely missed by us, pointing out the problem in searching publications not referenced in *Index Medicus*, such as the truly outstanding but now defunct *Continuing Education for the Family Physician*. This report was based on a residency training program in Sioux Falls and summarized 12 months of data. Their focus was the PriCare coding system, and their referral rate of 1 percent was again very similar to ours. We excluded Hines and Curry's work[3] because it was based in and near Toronto General Hospital, a large tertiary care teaching hospital, and most of the data was generated by practicing physicians acting as occasional preceptors. It included 12 months of data. Moscovice, et al.[4] based their study in rural Washington state and focused on the differences in referral among 2 general practitioners, 1 general surgeon, and 1 National Health Service Corps physician for a 4-month period in 1978.

Mayer's report[5] was excluded by us because the staff at the site, the Plymouth Clinic near Minneapolis, included an obstetrician and a pediatrician,

and consultations provided by them were not included in the report. This study included 3 family physicians' data for 12 months and had a higher rate of consultation (3.9 percent) despite the exclusions listed above. The work of Pagel,[6] a former fellow Huntsvillian, was of course well known to us. The topic by Pagel and Wood was the heroic effort in remote Alaska where there was no system of roads and focused on the issue of air transport of sick patients. Dr. Lawler's own work,[7] which was published after ours was written, again reports the experience from the Fulton, Missouri, training site. Consultations from faculty and a nurse practitioner were excluded, and 3 years of data, including 25,000 patient visits, were included. His finding of a referral rate of 1.31 percent is again very similar to ours.

It is truly heartening to see one's published work carefully scrutinized, as evidenced by Dr. Lawler's effort to suggest a more complete literature survey. It is the mark of a maturing discipline that active scientific debate occurs in the pages of its best journals. We hope this review has added to the reader's understanding of this important topic, and we are pleased to agree with Dr. Young that our report, with 9 years of data and almost 178,000 patient visits, "represents one of the largest reported series of observations regarding outpatient consultations emanating from a family practice teaching program."

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References

1. Glenn JK, Hofmeister RW, Neikirk H, Wright H. Continuity of care in the referral process: an analysis of family physicians' expectations of consultants. J Fam Pract 1983; 16:329-34.
2. Dolezel JM, Amundson LH, Sinning NJ, Hoody HJ. PriCare and ambulatory referrals. Cont Educ 1980; 12:84-94.
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7. Lawler FH. Referral rates of senior family practice residents in an ambulatory care clinic. J Med Educ 1987; 62:177-82.
8. Young PR. Editorial comment. J Am Bd Fam Pract 1988; 1:166.

Flexible Sigmoidoscopy

To the Editor: In their article on "Flexible Sigmoidoscopy" in the July-September 1988 issue, Dr. John E. Hocutt, Jr., et al. point out the many advantages to the family physician for performing flexible sigmoidoscopy on his or her patients.[1] I was alarmed, however, that they seem to imply that attending one of the numerous 1-day seminars in flexible sigmoidoscopy might qualify one to begin performing the procedure on patients. Many authors have shown that the procedure requires a number of supervised examinations before the examiner exhibits competence. In fact, the argument has revolved around just how many supervised procedures are necessary before performing the examination alone. Merely performing an examination does not necessarily mean that it was done properly. And with greater charges for flexible sigmoidoscopy versus rigid, how does one justify a limited or incomplete examination done while "self-training?"

With the ever increasing pressure about documentation for privileges, quality of medical care issues, and the competition among specialties, we as family physicians do not want to encourage our members to perform procedures without adequate training. Certainly, the Academy recognizes the need to promote hands-on training for flexible sigmoidoscopy because it expended a great deal of effort in setting up an extensive network of preceptors. Therefore, I would urge family physicians who wish to perform flexible sigmoidoscopy in their practice to arrange for hands-on training, if not through the Academy's programs, perhaps with the help of the faculty of a nearby family practice residency program.

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References

1. Hocutt JE Jr, Hainer B, Jackson M. Flexible fiberoptic sigmoidoscopy: its use in family medicine. J Am Bd Fam Pract 1988; 1:189-93.

The above letter was referred to the authors of the article in question, who offer the following reply: