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

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To the Editor: We readily agree there are numerous advantages for family physicians *and* their patients when family physicians have the ability to perform flexible sigmoidoscopy (FFS).

Dr. Glinka expressed concern that we implied it is acceptable for family physicians to go to a 1-day seminar and then start doing FFS on their own. Apparently he is referring to our sentence that states "numerous seminars . . . can *help* physicians get a good preparation for starting FFS in their office."(p 192) We believe the word *help* (highlighted here) is critical to a precise interpretation of the sentence. We believe many of the seminars offered around the country would be of benefit to the family physician starting FFS (many of which are more than 1 day), but we do not recommend that these seminars be the only preparation.

However, as we stated in the article, back when there were few if any willing preceptors, a number of us combined self study (articles, discussion, intermittent supervision) and control with simultaneous rigid and flexible instrumentation in informed and willing patients to learn the procedure well.

Now there are many more opportunities to receive direct supervision, and we strongly encourage all family physicians to take advantage of these preceptors and learn the procedure for themselves *and* their patients. We also recommend initial preparation prior to supervision to include seminar attendance and review of textbooks and articles.

Today, many family practice residents have the distinct advantage of learning FFS during their residency. Additional supervision, seminar attendance, self study, peer discussion, and videotape review would further enhance one's depth of knowledge on the procedure.

The situation in which preceptors are still not available for the family physician who desires to learn flexible sigmoidoscopy is somewhat more complicated. We suggest that if the physician is adept at procedures in general and patients are fully informed and if control is maintained according to the current standard of such a practice (i.e., rigid sigmoidoscopy), then the physician may consider learning the procedure using the previously described educational techniques.

Our sincere hope is that subspecialists will unite with family physicians in an effort to provide our patients with the best and largest variety of services available. Our patients are much better served when we all work together.

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Consultation/Referral Patterns

To the Editor: In Dr. Heiligman's editorial response[1] to our article on family physician consultation/referral patterns,[2] he makes reference to the ongoing debate in internal medicine circles about the appropriate role of the general internist. He suggests three categories of adult patients he believes are best referred to a general internist. These are:

1. "Patients who have multiple medical illnesses involving several organ systems, all of which are important and interrelated." In such patients, he believes that "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." Again, he cites the benefits that "an unbiased generalist" would lend.
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." In this situation, he suggests that the "generalist's cognitive skills may be more helpful than the subspecialist's procedural imperative."

Dr. Heiligman also suggests that referral to a general internist may well be advantageous "in complicated cases [where] three or four individual referrals to different subspecialists may be necessary . . . ." He correctly notes that this is "confusing for the patient and his/her family . . . [and] quite expensive."

We want to point out that in our article[2] we did not suggest the termination of general internal medicine training programs. We, too, believe that there are situations in which referral to a general internist rather than a subspecialist(s) is appropriate. We agree that the general internist can be very

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