The authors have done us all a great service with this study, both by removing some of the mysticism that surrounds this procedure, as well as by documenting that there are those in our specialty who are capable of being trained in its performance. If our efforts are to be given parity with those of others who perform EGDs, then we must document that we do them not only safely and efficaciously but for indications that do not significantly differ from the rest of the profession's.

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References

1. Sartor RB. Upper gastrointestinal endoscopy. In: Drossman DA, ed. Manual of gastroenterologic procedures. New York: Raven Press 1987:90.
2. Schwartz SI, Storer EH. Manifestations of gastrointestinal disease. In: Schwartz SI, Shires GT, Spencer FC, Storer EH, eds. Principles of surgery. New York: McGraw-Hill 1984:1048.

The above letter was referred to the authors who offer the following reply:

To the Editor: The study of esophagogastroduodenoscopy (EGD) by family physicians highlighted the patient group that might be viewed as the dyspepsia group. The study listed the top five indications and noted that many of these patients had two or more indications. This artificially skewed the distribution toward the dyspepsia group.

Nevertheless, there were a substantial number of patients in whom the investigation was conducted secondary to some variant of GI bleeding. We agree that hematemesis and melena are valid indications for EGD.

Unfortunately, many qualified family physicians have been effectively barred from EGD by their hospitals. GI bleeders frequently are more unstable and require hospital-based care. This is the reason GI bleeding cases are occasionally not done by family physicians who perform EGD in their offices.

As a specialty, family practice has not successfully created autonomous departments of family medicine that grant privileges in GI endoscopy. Obstetrics would be another example. Subsequently, our specialty is effectively excluded from participating. The American College of Obstetrics and Gynecology will not allow the induction of labor unless someone has Cesarean section privileges. This selectively penalizes family physicians. Additionally, there are very few family physician role models in those places where medical students and residents are trained. Family physicians with a broad set of skills, such as operative obstetrics and esophagogastroduodenoscopy, are usually not allowed to practice in teaching hospitals. This is an injustice that operates to the detriment of our patients everywhere.

The Residency Review Committee should require that every residency training program have at least one or two family physician faculty who can practice a broad array of skills, such as operative obstetrics and EGD. Currently, most medical students are being instructed that these skills are not within the reach of the family physician.

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Books Received

Infections in Pregnancy. By Larry C. Gilstrap, III, and Sebastian Faro. 277 pp. New York, Alan R. Liss, Inc., 1990. $58.

Lying-In: A history of childbirth in America, expanded edition. By Richard W. Wertz and Dorothy C. Wertz. 322 pp. New Haven, CO, Yale University Press, 1989. $35 (cloth), $15.95 (paper).

National Boards Part I. Second edition. By Michael Caplan. 272 pp. East Norwalk, CT, Appleton & Lange, 1990. $30.95 (paper).

The Office Laboratory. Second edition. By Lois Anne Addison and Paul M. Fischer. 422 pp. East Norwalk, CT, Appleton & Lange, 1989. $59.

Off the Pedestal. Transforming the business of medicine. By Michael A. Greenberg. 163 pp. Houston, TX, Breakthru Publishing, 1990. $14.95.

Prevention of Sudden Cardiac Death. By John B. Kostis and Michael Sanders. 316 pp. New York, Wiley-Liss Division, 1990. $69.50.

Sports Injuries: Diagnosis and management. By James G. Garrick and David R. Webb. 369 pp. Philadelphia, W.B. Saunders, 1990. $45.