

even mind-body relations or the possibility of psychogenesis. I have been hung up on dichotomies when I should have seen that the most egregious failure in medical care is the failure to take patients' narratives into account. Every illness becomes incorporated into a particular patient's life narrative, for better or worse, and the failure to see that is a missed opportunity for a potentially therapeutic interaction between physician and patient.

What I fear is losing the interest and capacity for creating the sort of intimacy in which the patient's narrative can be discovered, at least in part. I do not imagine that I can know each patient's narrative thoroughly, but surely I can do better than structuring my life and work so that I never have to deal with the narrative. If I do that, I am doomed to treating each illness as an isolated event having no relevance beyond itself.

Stanley Hauerwas<sup>9</sup> has suggested that our culture's repertoire of stories about illnesses has undergone attrition and that modern people are likely to see their illnesses as "pointless," that is, having no larger meaning in the drama of human life. In the face of that loss, we are more likely to abandon ourselves and our loved ones to medicine to do with us whatever it can. When suffering, disability, and death become inevitable, we endure them without a cultural narrative that can give them any point. As a theologian, Hauerwas hopes that we can recover the part of our cultural heritage that evokes faith in the larger benevolence of life, without resorting to obsolete theodicies that attempt to read the mind of God.

Whatever the merits of Hauerwas's position, it seems clear that illness and disease of all sorts are dealt with best when patients are supported by a community of belief that gives them meaning as a part of life and that death, too, belongs to the category of cultural narrative. Death is not merely the tragic end of life, but an event occurring within a living community. What we all need is less an explanation for the evil that assails us than a "community capable of absorbing our grief."

Any truth in psychological explanations? That form of the question interests me less now than it did at the beginning. It doesn't matter much when there is a story to be discovered and ten-

tatively interpreted in terms of folk psychology. The clinical problem is that we all need a little help now and again in interpreting our own experiences. Physicians, when they are so inclined, have special opportunities to do that.

G. Gayle Stephens, M.D.  
Birmingham, AL

## References

1. Forward S. *Toxic parents: overcoming their hurtful legacy and reclaiming your life*. New York: Bantam Books, 1989.
2. Hirschfeld R. Depressive illness: diagnostic issues. *Bull Menninger Clin* 1991; 55(2):144-55.
3. Brown T. Holzman's fences. Chauvinism or confusion? *Arch Gen Psychiatry* 1986; 43:910-2.
4. Spurgin M. Vadas' viral virilization—fact or fable? *Newsletter. Am Philosophical Assoc* 1990; 90(1): 136-9.
5. Waterson B. Calvin and Hobbes (cartoon). Birmingham, AL: *The Birmingham News, Comics*, May 26, 1991.
6. Glick ID, Showstack JA, Cohen C, Klar HM. Between patient and doctor. Improving the quality of care for serious mental illness. *Bull Menninger Clin* 1989; 53(3):193-202.
7. Berg M, recorder. *Transactions of the Topeka Psychoanalytic Society. Bull Menninger Clin* 1991; 55(2):254-8.
8. Bruner JS. *Acts of meaning*. Cambridge, MA: Harvard University Press, 1990:33-65.
9. Hauerwas S. *Naming the silences: God, medicine, and the problem of suffering*. Grand Rapids, MI: William B. Eerdmans, 1990:ix-xiv.

## Colposcopy Training For Family Physicians

The technique of colposcopy was originally described by Hans Hinselman in 1925.<sup>1</sup> Although the procedure was accepted in Europe, there was very little interest generated in the United States until 1964, when a small group of interested gynecologists formed the American Society of Colposcopy and Colpomicroscopy. During the next

Submitted 30 July 1991.

From the Department of Family Medicine, School of Medicine, Seattle, and the Department of Family Medicine, University of Washington, Spokane. Requests for reprints should be addressed to James Nuovo, M.D., Department of Family Medicine, University of Washington, Seattle, WA 98195.

20 years interest and acceptance of colposcopy were widespread. Departments of obstetrics and gynecology throughout the United States implemented colposcopy training for their residents. As reviews of these training programs were eventually performed, it became clear that residents could learn the cognitive and technical components of the procedure and demonstrate competence.<sup>2,3</sup>

Recently, family physicians have shown interest in acquiring the skills necessary to provide colposcopy services in their practices.<sup>4</sup> The reason for this interest is clear. Human papillomavirus (HPV) infection of the lower genital tract has increased in incidence and now may be the most common sexually transmitted viral disease.<sup>5,6</sup> The epidemic of the HPV infection has been accompanied by an increased abnormal Papanicolaou smear rate and need for early evaluation and treatment of cervical dysplasia. Genital HPV infection is clearly correlated with cervical dysplasia.<sup>7-9</sup> Many practicing family physicians recognized the need to provide colposcopic services for their patients. Residency programs responded by developing colposcopy training programs for their own faculty and residents.<sup>4,10</sup> The intensity of this interest is reflected by the finding of a recent national survey of 376 family practice training programs.<sup>11</sup> Data from the survey indicated that 59 percent of family practice residency programs nationwide currently provide colposcopy training and that 40 percent of the remaining programs not currently providing training are in the process of developing a colposcopy training experience. From this report it is clear that providing training in colposcopy in a family medicine residency program has assumed national interest. Given the extent of residency training available, we should expect that in a relatively short time most family medicine graduates will be exposed to this skill.

Reviews should follow ascertaining the effectiveness of the training offered and ultimately the ability of graduates to provide these services to their patients. In the meantime, what of the family physicians who were not exposed to formal colposcopy training? How do these individuals achieve adequate training, and what has been their experience in providing colposcopy services? What barriers do they find by includ-

ing colposcopy in their practices? In this issue of *JABFP*, Gordon and Weiss<sup>12</sup> address some of these questions. They present the results of a survey of 757 self-identified family physicians in Arizona. Several findings come from their work: (1) 19.3 percent of respondents received formal training in colposcopy; (2) 9.5 percent of respondents actually provide the service to their patients; (3) of 81 family physicians trained in colposcopy, 63 percent did not receive training during residency; and (4) the barriers to family physicians performing colposcopy identified in this study included lack of available training, "turf battles," concerns for quality assurance, and cost of malpractice liability insurance.

Although it may be unfair to generalize this regional report to a national experience, several important general issues are raised. It comes as no surprise from these data that a great number of family physicians currently performing colposcopy have not experienced formal training during their residency programs. The current situation for family physicians seeking colposcopic training is not unlike that of practicing gynecologists 30 years ago, when colposcopy was introduced and widely advocated as the necessary procedure to evaluate the abnormal Papanicolaou smear. For a number of years the American College of Obstetrics and Gynecology had offered a series of colposcopy workshops initially designed for practicing gynecologists who did not receive formal colposcopy training during their residency. Indeed, to a very real extent, all practicing physicians among all the specialties must rely on continuing medical education opportunities to provide procedural or cognitive enhancement of skills directly applicable to their practice of medicine. Currently, a number of high-quality colposcopy workshops have become available, with faculty derived from the ranks of family physicians, gynecologists, and pathologists.

Legitimate questions still arise regarding what constitutes adequate training, not only for colposcopy, but for any procedural or cognitive skill physicians acquire during their postresidency years. How does the family physician become skilled at colposcopy? How many take advantage of a precepted environment to reinforce the skills they have learned from introductory continuing medical education (CME) experiences?

Who does the precepting, the family physician or the gynecologist? What are the mechanisms to ensure quality of care? These questions underscore the work by Gordon and Weiss. While it is important for family physicians who elect to provide colposcopy services to be adequately trained and ultimately competent, there remains a potential danger to establish unrealistic guidelines that might result in unnecessary barriers. A primary force prompting family physicians to seek these skills reflects the tremendous, ubiquitous rise in the abnormal Papanicolaou smear rate, which may ultimately become an issue of access to care for many women, urban and rural alike.

The current study by Gordon and Weiss suggests that most family physician colposcopists surveyed obtain their training through CME courses, with a number seeking precepted experience as well. Adequate training and ultimately "competency" for any procedural skill remain difficult to define and require thoughtful clarification. This study stimulates other areas of inquiry. For instance, a substantial number of family physicians who received colposcopy training in their residency programs are not yet performing colposcopy in their practices. What barriers are keeping them from providing this service for their patients? Gordon and Weiss's data focus on "turf battles," malpractice insurance, concerns for quality, and lack of available training as contributing factors. Other issues are suggested as well. For instance, to what extent does the cost of acquiring necessary equipment, lack of adequate practice demand, availability of specialist support, or geographic location contribute? Working from the reasonable premise that all physicians strive to provide skilled and competent care for their patients, further studies are needed to clarify the lessons to be learned from successful family physician and gynecology colposcopists who have acquired their skill from postresidency training experiences. These lessons should certainly include input from gynecology and family medicine residency faculty who may be already intimately involved with teaching these skills to their residents.

The data presented by the above-mentioned study constitute an important early step in the difficult process of clarifying issues generic to procedural skill competency acquisition. The skilled family physician colposcopist appears to

be in an ideal position to address a major public health problem and make a significant contribution to the health care of women within their practices.

James Nuovo, M.D.  
Gary R. Newkirk, M.D.  
Seattle and Spokane, WA

## References

1. Weese WH. A brief history of colposcopy. *J Reprod Med* 1976; 16:209-11.
2. Kelley J, Whitehouse HH 3d, Dillard EA Jr. The colposcopy clinic in a residency training program. Five years' experience with colposcopically directed biopsies followed by conization or hysterectomy. *J Reprod Med* 1983; 28:127-30.
3. Homesley HD, Wolff JL, Reish RL, Jobson VW. Evaluating the acquisition of colposcopy skills in an obstetric-gynecologic residency program. *J Reprod Med* 1985; 30:911-4.
4. Newkirk GR, Granath BD. Teaching colposcopy and androscopy in family practice residencies. *J Fam Pract* 1990; 31:171-8.
5. Oriel JD. Condylomata acuminata as a sexually transmitted disease. *Dermatol Clin* 1983; 1:93-102.
6. Nuovo GJ, Crum CP, Silverstein SJ. Papillomavirus infection of the uterine cervix. *Microb Pathog* 1987; 3:71-8.
7. Lorincz AT, Temple GF, Kurman RJ, Jenson AB, Lancaster WD. Oncogenic association of specific human papillomavirus types with cervical neoplasia. *J Natl Cancer Inst* 1987; 79:671-7.
8. Reid R, Greenburg M, Jenson AB, Husain M, Willett J, Daoud Y, et al. Sexually transmitted papillomavirus infections I. The anatomic distribution and pathologic grade of neoplastic lesions associated with different viral types. *Am J Obstet Gynecol* 1987; 156:212-22.
9. LaVecchia C, Franceschi S, Decarli A, Fasoli M, Gentile A, Parazzini F, et al. Sexual factors, venereal disease, and the risk of intraepithelial and invasive cervical neoplasia. *Cancer* 1986; 58:935-41.
10. Caruthers BS, Sheets KJ. Development of a curriculum in colposcopy. *J Fam Pract* 1991; 32:590-7.
11. Gordon P. Colposcopy training in family practice residency programs. *Fam Med* 1991; 23:310-2.
12. Gordon P, Weiss B. Family physicians' colposcopy practices. *J Am Board Fam Pract* 1992; 5:27-30.

## Sorry, I Don't See Nursing Home Patients

I am a geriatrician, and my office gets many calls from families and hospital social workers asking