

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.

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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

whether I will take patients moving to nursing homes. I have found that many of these patients have been treated by family physicians or internists — often for as long as 20 years — who have chosen not to care for them after they are admitted to a nursing home. Just like that.

I have also noticed that many of the new primary care physicians coming into the community have decided not to accept nursing home patients.

I have several concerns about what is happening. First, the refusal of many of my colleagues to continue or assume care of nursing home patients is putting a major burden on me and on those physicians who do see nursing home patients. We are overwhelmed with the demand, and I suspect the situation is similar elsewhere. I am finding it increasingly necessary to refuse new nursing home patients because I cannot give them the quality of care that I want to provide and that they deserve.

In my community of more than 650 active members of the state medical society, about 90 percent of the nursing home care is provided by 10 primary care physicians. That situation is not good.

Second, I am concerned about the rationale that allows my colleagues to drop their patients when they enter nursing homes. More than most physicians, I clearly understand the problems of providing long-term care. Reimbursement is poor, demands are substantial, and the hassle factor is high. Moreover, from a medical standpoint, these patients are not easy to care for. Still, how do we justify saying no to this needy population?

Consider for a moment if a physician said, "I don't take care of black people." That statement would almost certainly cost the physician his or her medical license — as it should. Or consider if one said, "I don't see Italians." That statement would certainly cause the physician a lot of trouble in the community, even if his or her license were not revoked. Yet, "I don't take care of nursing home patients" is not only accepted, but it is at times even well-received and encouraged. For example, I have had social workers explain,

"Doctor X gets too depressed in nursing homes," and families say, "Doctor X really likes Mom, but he is *too busy* to go to the nursing home" (emphasis mine).

I get depressed in nursing homes, too, and I am just as busy as anyone else. I think these physicians are taking the easy way out. They are choosing to opt out of the admittedly deep and muddy waters of long-term care. They know the patients, they know the families, and they are the physicians best suited to continue caring for them. I hereby challenge them to keep their patients and treat them in the nursing home. And if they do not like the system, I ask them to help us change it rather than run away from it.

I am most concerned about the younger primary care physicians who are choosing not to have anything to do with nursing home patients. Are we developing an entire generation of family physicians and internists who will not provide any nursing home care? We need to get them involved.

Historically, most long-term care has been provided by physicians who in academic circles are disparagingly called "nursing home docs." Now that I have worked in long-term care for more than 10 years, I can tell you that most of these nursing home physicians did and continue to practice pretty good medicine under difficult circumstances.

Yet we nursing home physicians, and I use the term with pride, continue to be harpooned both by community subspecialists and by our academic colleagues. Consider this statement from a new textbook of geriatric medicine: "All too often in the past care of older patients had been relegated to physicians of borderline capabilities, with the benefits derived by older patients equally marginal."¹

I ask you: Is there really a Great Relegator out there directing good physicians to the subspecialty clinics and to the halls of the university hospital and sending bad physicians to nursing homes?

It worries me that physicians in training will read that quotation and others similar to it. It concerns me that younger primary care physicians have during their training programs been turned off by long-term care before they can judge and experience it for themselves.

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We need good young physicians to get involved in the care of nursing home patients. We need their input, their expertise, their energy. They can help us improve nursing home care and advance the discipline of geriatric medicine. By opting out of long-term care before they even give it a chance, they deny older patients access to young and talented physicians; at the very same time, they deny themselves exposure to an exciting and challenging area of medicine. We can attract some of these young physicians to geriatric care, but not if we never have the opportunity. And geriatric medicine will not advance if the myth of "marginal" nursing home physicians is perpetuated in our profession.

I close with four requests and one acknowledgment:

To established primary care physicians: Keep your patients when they are admitted to nursing homes within your area.

To academic physicians: Don't prejudice your students against long-term care.

To younger primary care physicians: Give long-term care a chance. We need you.

To all my colleagues: Give nursing home physicians the support and the respect they deserve.

And to all you "nursing home docs" out there: Thanks for doing a very good and unrecognized job.

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