

trous effects of erroneously labeling this patient were avoided by waiting until a dermatologic consultation was obtained. The patient referred himself to counseling to explore further social and psychological issues.

Amy L. Robinson, MD
Glenn A. Koester, MD
Arthur Kaufman, MD
University of New Mexico
Albuquerque

1. Feldman GC. *Lessons in Evil: Lessons From the Light*. New York, NY: Crown Publishers; 1993.
2. Sisson WR. Colored striae in adolescent children. *J Pediatr*. 1954;45:520-530.
3. Grantham VA. Lumbar striae in adolescents. *Practitioner*. 1982;226:1311-1312.
4. Gardner RA. *True and False Accusations of Child Sex Abuse*. Cresskill, NJ: Cresskill Therapeutics; 1992:491-521.

Procedures in Family Medicine: Serving as Our Own Gatekeeper

I want to write in support of the editorial by Dietrich and Kotrady.¹ As the residency director at Bowman Gray School of Medicine, I, and others in my position, are constantly faced with trying to decide what procedures to select and how extensively to train our residents in the procedural aspects of family medicine. One of the principles that has slowed our pursuit of these procedural skills is the recognition that the primary care physician who chooses to perform procedures will often experience an increase in utilization of those procedures. It has been our suspicion that physicians who perform colposcopy, treadmill, and other procedures may, in fact, do those at a greater rate on their patients than if they had to refer the same patient to an outside consultant.

The authors posed a number of useful questions for determining when a procedural skill was worth adding to a practice. Concerns about the expertise of the examiner, the frequency of the examination, the access to similar services in the area, and issues around reimbursement are critical features to be considered. Programs that train residents and practicing physicians to perform procedures must recognize the need to provide more than technical skill. Training must include assessment of the risk-benefit ratio, proper patient selection and preparation, diagnostic interpretation, and follow-up.

Clearly, one of the most important features, as the authors noted, is the issue of how a procedure will affect the provision of care. As primary care physicians move into the role of gatekeeper, we must recognize that it is difficult for us to be our own gatekeepers

when it comes to procedural medicine. I applaud Dietrich and Kotrady for taking a very educated look into the issue of procedural aspects of medicine.

Mark P. Knudson, MD
Bowman Gray School of Medicine
Wake Forest University
Winston-Salem, NC

1. Dietrich AJ, Kotrady KP. Procedures in family practice: what's best for your patients and for you. *Arch Fam Med*. 1993;2:1028-1030.

Growth of Diagnostic Skills in Family Practice

The recent documentation of the prevalence of various procedural skills among one group of family physicians is an important milestone symbolizing the impact of family practice as a social reform within the overall structure of academic medicine.¹ These data can be analyzed from a separate perspective to predict future needs for the specialty and can suggest curriculum changes within family practice residency training programs.

By comparing the number of those physicians who currently practice a skill with those who report a desire to practice in the future, certain growth areas can be identified. The published data represent a "snapshot" of early 1989. Five years have passed since that time.

As a coordinator for regional, state, and national continuing medical education, I have observed the growth trends of flexible sigmoidoscopy skills and have used that to predict similar trends for colposcopy, colonoscopy, esophagogastroduodenoscopy, obstetric ultrasonography, and others.²⁻⁶ The Washington Academy of Family Physicians is fortunate to have 406 (54%) of 750 respondents delivering newborns. Comprehensive family practice skills are frequently stifled by practice settings where subspecialty colleagues do not support a broad array of procedural skills.⁷ A statistical correlation regarding skills in obstetrics, ultrasonography, colposcopy, and colonoscopy with type of practice arrangement might support or refute this hypothesis.

For 10 years, as faculty, we have taken an informal poll of physicians attending the American Academy of Family Physicians Scientific Assembly course on flexible sigmoidoscopy and colonoscopy services. These data have been tabulated using a combination of written surveys and hand counts. Family physicians' response rates averaged 80% (**Table**).

It should be noted that many academic medical centers have resisted the performance of these proce-

Frequency of Colonoscopy Interest Among Registrants to the AAFP Lower Gastrointestinal Endoscopy Course*

Description	No. of Physicians		
	1984	1988	1993
Total registration	200	200	175
Does not perform flexible endoscopy of any kind	133	78	29
Performs flexible sigmoidoscopy	15	70	98
Uses a 35-cm flexible sigmoidoscope	7	10	2
Uses a 60- to 70-cm short colonoscope	8	60	96
Wants to learn colonoscopy	0	10	74
Performs full colonoscopy now	0	3	32

*AAFP indicates American Academy of Family Physicians.

dural skills by family physicians. The Washington Academy of Family Physicians should be commended for establishing a procedural teaching network. Tragically, the powerful lobbies of the Association of the American Medical Colleges and the American Hospital Association have steadfastly attempted to lump family practice into a generic primary care model that suppresses procedural skills and obstetrics for family physicians.

These diagnostic skills remain as "forbidden fruits" in many of our family practice residency training programs. This is particularly true for such things as obstetric ultrasonography, colonoscopy, and cesarean section. These obstacles should be noted as a selection bias that artificially lowers the prevalence of these useful skills among practicing family physicians. Family practice would be well served by following these trends at 5-year intervals and using these data to solicit support from the academic establishment.

William MacMillan Rodney, MS
The University of Tennessee
Memphis

1. Phillips WR. Diagnostic and screening procedures in family practice: past, present, and future use. *Arch Fam Med.* 1993;2:1051-1057.
2. Rodney WM. High tech is most effective when blended with high touch and vice versa: office technology in the 21st century. *Fam Pract Res J.* 1991;11:235-239.
3. Rodney WM, Prislis MD, Orientale E, McConnell M, Hahn RG. Family practice obstetric ultrasound in an urban community health center. *J Fam Pract.* 1990;30:163-168.
4. Rodney WM. Flexible sigmoidoscopy and the despecialization of gastrointestinal endoscopy. *Cancer.* 1992;70(suppl 5):1266-1271.
5. Rodney WM, Dabov G, Cronin C. Evolving colonoscopy skills in a rural family practice: the first 293 cases. *Fam Pract Res J.* 1993;13:43-52.
6. Rodney WM, Weber JR, Swedberg JA, et al. Esophagogastroduodenoscopy by family physicians, phase II: a national multisite study of 2500 procedures. *Fam Pract Res J.* 1993;13:121-131.
7. Rodney WM. Obstetrics enhanced family practice: an endangered species worth saving! *Fla Fam Phys.* 1993;43:8-9.

Colposcopy for Family Physicians

I am writing in response to the article by Phillips¹ and its accompanying editorial by Dietrich and Kotrady² in the October 1993 issue of the ARCHIVES. I specifically want to address the comment that colposcopy should not be added to the basic list of family physician skills.

The family physician excels at screening and early detection and treatment of most all cancers for which there is an effective screening method. The Papanicolaou smear is the oldest, most studied, and most useful of these methods. The indirect evidence supporting this is the 69% decrease in the number of cervical cancer deaths in the past 30 years.³ Forty percent of all Papanicolaou smears done in the United States are performed by family physicians, an estimated 28 million per year.⁴ Phillips¹ infers that 97% of family physicians who are members of the Washington Academy of Family Physicians are currently practicing cervical cancer screening in the form of Papanicolaou smears. With the health system environment advocating the use of primary care physicians instead of the procedure-oriented specialists, the percentage of Papanicolaou smears performed by family physicians will increase.

Using the revised Bethesda System⁵ (1991) for Papanicolaou smear reporting, the percentage of abnormal results of Papanicolaou smears has increased from 5% to 15% in the average-risk population.⁶ In the high-risk population, the results of up to 40% of Papanicolaou smears are now read as abnormal.⁷ These abnormal results of Papanicolaou smears include, but are not restricted to, the identification of cervical dysplasia. Cervical intraepithelial neoplasias are not cancer; they are preinvasive lesions that can be treated conservatively with virtually 100% success. How much more effective can a family physician be in detecting and treating early precancerous changes!?

Providing colposcopy services gives the family physician the standard-of-care tools needed to make the appropriate tissue diagnosis in the appropriate workup sequence. Phillips¹ showed that 34% of the members of the Washington Academy of Family Physicians were already doing cervical biopsies and 51% were performing endocervical curettage, yet only 6% were doing the biopsy and endocervical curettage under colposcopic guidance, implying that 28% were performing blind biopsies. If family physicians are to be partners with the gynecologists in screening and treating cervical dysplasias, we all need to follow the same rules. Let us encourage these physicians, the 20% who intend to begin performing cervical biopsies, the 12% who intend to begin performing endocervical curettage, and the 30% who intend to begin performing colposcopy, to attend a colposcopy continuing medical education conference to become acceptably trained to provide standard-of-care biopsies.