

ANDROSCOPY

To the Editor:

Dr Epperson's article on androscopy (*Androscopy for anogenital HPV. J Fam Pract 1991; 33:143-6*) is an excellent illustration of practical primary care research in private practice. Our specialty should encourage similar efforts.

There are several questions I cannot answer, however, despite extensive analysis of the article:

1. If 65% (33 patients) had HPV-related anogenital lesions, why was treatment carried out on 39 patients (77%) with HPV-related lesions?
2. Who were the 12 patients with no lesions to biopsy (eg, from the group of 14 patients, 27% were found to be free of disease at the initial visit)?
3. What was the average duration of follow-up? The significance of a 79% treatment response must be viewed in light of the timing of follow-up examination, especially given the recurrence risk.

Although human papillomavirus (HPV) lesions are sometimes clinically obvious, at other times they present a diagnostic challenge. In this study, one third (10 of 29) of biopsies of "suspect lesions" revealed disease unrelated to HPV infection. As in other aspects of medicine, we must be certain of our diagnosis before embarking on a treatment course.

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The preceding letter was referred to Dr Epperson, who responds as follows:

I wish to comment on the questions Dr Shute has raised in his letter. There were 51 patients in the study. Ten patients were self-referred for obvious human papillomavirus (HPV) lesions, and 41 patients were referred by a physician for androscopy because their female sexual partners had confirmed cervical intraepithelial neoplasia (CIN). Twenty-nine (19 were biopsy proven and 10 had obvious lesions on androscopy) of the 41 physician-referred male patients exposed to female patients with CIN had anogenital HPV (70%). There were 12 patients from the group of 41 with no lesions (29%). The article does report these as 65% and 27% incidence rates, which is in error. All 29 HPV patients who were found to have previously undiagnosed anogenital HPV were treated along with the 10 self-referred HPV patients. This gives a total of 39 patients treated for HPV.

In summary, the study contained 12 physician-referred patients with no HPV disease, 10 patients self-referred for obvious HPV disease, 10 patients who were physician-referred and found to have clinically obvious (no biopsy indicated) HPV disease on androscopy, and 19 physician-referred patients who had biopsy proven anogenital HPV. This gives a total of 51 patients in the study.

Patient follow-up time was at least 6 months post-treatment in each individual who was compliant with follow-up recommendations.

I appreciate Dr Shute's comments and interest.

Wm Jackson Epperson, MD
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PRACTICE-BASED RESEARCH

To the Editor:

In his thoughtful editorial on family practice research networks, Holloway (*Networks and net worth: practice-based data collection in family medicine. J Fam Pract 1991; 33:137-9*) raised several valid questions that deserve further introspection and investigation. However, as a practicing family physician who also conducts research, I believe several other points that Dr Holloway did not consider must be entered into the intellectual equation we use to evaluate the utility of practice-based research.

Holloway contends that university-based patient populations constitute a representative sample of family practice patients, but in this respect he is mistaken. First, with few exceptions, university-based family practice residency programs are located in urban areas. Basing family medicine research on university-based patient populations ignores the special health care needs and attitudes of rural populations. Second, by the very nature of their transitory practice, patients in university-based residency programs cannot develop the long-standing physician-patient relationship that colors many of the behaviors and attitudes of both parties.

In addition, a more important reason for encouraging practice-based researchers and research networks deals with the development of our research questions. If we sever practicing physicians from the process of generating research questions, we will surrender the content of our specialty to academicians who will be entrusted to decide which questions are important. This separation of research and practice will eventually lead to an academic-community schism that will leave our research journals being of interest only to our

researchers. Holloway acknowledges the importance of practicing physicians in the development of research questions, but I am uncertain how this intangible variable will be reflected in his cost-benefit analysis.

While Holloway is correct in stating that collaborative research is expensive, I fear that his comments may discourage further development of successful practice-based groups. Such small networks as MIRNET and WREN have produced insightful research germane to clinical practice; these grass-roots networks operate at a fraction of the cost of the large university-administered networks and should be nurtured by our academic colleagues rather than discouraged.

*William J. Hueston, MD
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The preceding letter was referred to Dr Holloway, who responds as follows:

Dr Hueston is to be commended for raising several important points about the issues of practice-based research and representative sampling. He is also to be commended for participating in research as a practitioner; he embodies just those attributes that make such collaborative efforts worthwhile.

Although my editorial was admittedly nonspecific on the subject of encouraging practitioners to generate research questions, my own experience is a good deal more tangible, having participated in numerous collaborative ventures involving the practicing community. I have enjoyed a long-term relationship with Dr Milton Seifert of Excelsior, Minnesota, and the process of collaboration with him has been both gratifying and productive. This relationship extends far beyond the relatively simplistic idea that practitioners identify ideas for university researchers to examine. It is, in fact, a respectful recognition of our different skills and backgrounds, leading to a nearly constant interplay between us. I

agree with Dr Hueston that there is danger of a university-practice schism if such relationships are not nurtured. My point was not so much that we should isolate our interests as that we should acknowledge and support our different *roles* in the research process. It is my belief that by ignoring important role differences we create a higher risk of a schism than we do by working through them honestly. I would even go so far as to say that a healthy respect for these differences will increase research productivity.

As for Dr Hueston's points about the nature of sampling (ie, what constitutes a "representative" sample of family practice patients), he has raised an important question about the variables that exist in family medicine research. None of these variables, however, preclude the use of a university-based site as a data collection instrument per se. A university site may or may not ignore the "special needs and attitudes" of a rural population. Dr Hueston's comments underscore my basic point that these issues need not be couched in anti-university sentiment but that they should be examined purely from rigorous scientific principles. If a rural population is the target, the sample certainly must be rurally based. That rural sample could occur in any number of settings, perhaps at a university site, in a practice, or in any of the more than 100 residencies that have declared a special interest in, or are located in, rural areas. If continuity of care is an important variable, I agree that it may be unlikely that a residency program would offer a useful sample.

The interest in practice-based research is strong enough that I suspect my comments will not deter its development; nor should they. My only hope is that decisions about networks will be based on science, not emotion.

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ENVIRONMENTAL HEALTH RESOURCES

To the Editor:

Dr Hendee is to be congratulated for clearly articulating the reasons why family physicians should be concerned about radon in the homes of their patients (*Hendee WR. Radon and the Family Physician. J Fam Pract 1990; 33:95-6*). This paper brings up a more general issue: the role of environmental health in family medicine.

Recently, the Institute of Medicine of the National Academy of Sciences concluded that physicians need to be better able to diagnose and manage cases in which environmental pollutants cause patients' health problems. Often, however, primary care physicians have little training in environmental health; sometimes it is even difficult for them to find suitable resource materials in this area. Therefore, I wish to call to the reader's attention two excellent entry points into the literature on environmental health in primary care.

The first, *Environmental Issues in Primary Care*, is a very practical 76-page book that contains an overview of drinking water and air pollution as well as a basic discussion of metal contaminants (eg, lead) in the home. Background information is given, as is advice about diagnoses and remedial actions that patients and primary care physicians should take. The second excellent point-of-access into this literature is a series of environmental medicine case studies by the Agency for Toxic Substances and Disease Registry. The lead, vinyl chloride, and methylene chloride cases have been published, and several more will be released soon. Each case study is rich in clinical detail; information about diagnosis and management is given. Physicians who study this series and complete a short test on each case study can earn CME hours.

Environmental contaminants can cause serious health problems in the patients of family physicians. The two sources cited here provide an

excellent starting point for those physicians wishing to study the area further.

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Suggested Resource Materials

Murdock BS, ed. *Environmental Issues in Primary Care*. Wayzata, Minn: Freshwater Foundation, 1991. Cost is \$30; phone 612-449-0092 or write Health and Environment Digest, Freshwater Foundation, Springhill Center, 725 Country Road #6, Wayzata, MN 55391.

Agency for Toxic Substances and Disease Registry. *Case Studies in Environmental Medicine* (series). Atlanta, Ga: US Department of Health and Human Services, Public Health Service, 1990. Membership on series mailing list is free of charge at this time; phone 404-639-0730 or write ATSDR, Continuing Education Coordinator, Division of Health Education E33, 1600 Clifton Road, Atlanta, GA 30333.

VISITING PROFESSOR SERIES

To the Editor:

Two years ago, our residency program initiated a visiting professor series. Visiting professors spend one evening and one full day in the department. During this time, they present a grand rounds address to house staff and faculty that covers a philosophical or pragmatic aspect of family medicine, and a continuing

medical education lecture to the county chapter of the Academy of Family Physicians. Visiting professors also attend morning report and inpatient rounds, meet one-on-one with selected faculty to discuss topics of shared interest, and meet informally with residents during a "social hour." Special activities such as participating in an audiovisual review session or precepting residents treating elderly patients in a nursing home can be arranged to match each visiting professor's special interests.

The Visiting Professor series has been operational for the past 2 academic years. Funding is provided through a private foundation grant. Evaluation of the program, thus far, has been conducted by questionnaires filled out by program participants. Initial evaluations have been very positive.

The benefits of the Visiting Professor series to our Department have included:

1. *Improved morale among residents and faculty.* The Visiting Professor series includes physicians who have demonstrated their ability to inspire young physicians. Speakers are encouraged to choose topics with broad philosophical applications such as the future of family medicine, the relevance of the family to family medicine, and the family doctor's role in geriatrics. Several recent articles¹⁻³ have discussed the importance of adequate mentoring opportunities for family practice faculty. Through the program, our faculty have benefited by exposure to potential mentors.

2. *Development of closer liaisons with community physicians.* A schedule of addresses to the local Academy by outstanding medical educators serves to strengthen the bond between the residency program and those preceptors already involved in teaching.

3. *Development of networking contacts to bolster medical student applications to this residency program.* Most of the visiting professors are chairpersons in major academic settings. These individuals often have close contact with medical students. Our hope is that visiting professors will go back to their programs and encourage students to apply for a residency position in our program.

In the past 2 years, we received 21 residency applications, and recruited one acting intern, from medical schools represented by the five visiting professors. Several of these applicants based their decision to apply on input from a professor who had visited our program as part of the series.

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References

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2. Stange KC, Hekelman FP. Mentoring needs and family medicine faculty. *Fam Med* 1990; 22(3):183-5.
3. Rogers JC, Holloway RL, Miller SM. Academic mentoring and family medicine's research productivity. *Fam Med* 1990; 22(3):186-90.