Letters to the Editor

The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Acknowledgement of Society of Teachers of Family Medicine

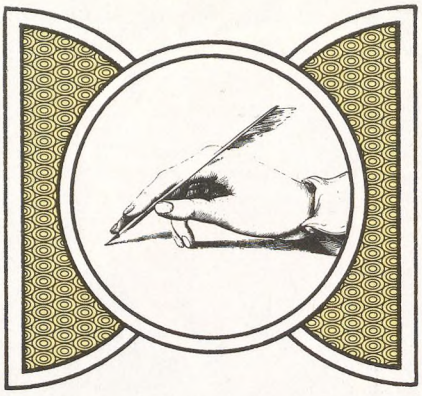
Through an unintentional oversight, acknowledgement of the role of the Society of Teachers of Family Medicine was not included in the July 1979, Special Issue of *The Journal of Family Practice* on "Preventive Medicine in Family Practice." Five of the nine papers in that issue (Medalie; Frame; Froom et al; Thompson; Grove et al) were adapted from presentations made at the October 1978, STFM meeting in New Orleans, Louisiana, on the theme of "Family Medicine and the Boundaries of Health." The efforts of Frank Snope, MD, Program Chairman of the STFM, in planning the meeting and in making available drafts of the presentations for editorial review by *The Journal*, are gratefully acknowledged.

--the Editor

Continuing Medical Education Requirements

To The Editor:

The commentary by Lawrence on the continuing education policies of The American Board of Family Practice (*Lawrence DA: J Fam Pract 8:407, 1979)* may be read at two different levels. At the factual level some of his specific points have merit, although the problem may be more complex than a reading of the paper would suggest. Considering the issue of



style, the essay in question appears to be an attempt to solve a problem by polarization and confrontation rather than by persuasion and conciliation. Readers will note phrases like "woeful shortsightedness," "grave oversight," and the concluding prediction that by 1983 the ABFP "will no longer be represented by the mythological phoenix rising from the ashes, but rather the proverbial ostrich with its head buried in the sand."

There are also some places in the article where complex issues have been oversimplified. One example is the paragraph in which the ABFP is accused of judging journal reading, teaching of medical students and residents, hospital staff meetings, and university hospital teaching rounds to be "of *no* value to the practicing physician" (emphasis in original).

Hopefully Lawrence's essay will stimulate further thinking at both levels: defining and measuring appropriate continuing medical education experiences for family physicians; and communicating in a way which creates a maximum amount of progress.

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To The Editor:

I cannot strongly enough support the thoughts of Duane A. Lawrence, MD, in his article entitled, "The American Board of Family Practice: Phoenix or Ostrich in 1983?" in the Family Practice Forum of the February issue of *The Journal of Family Practice* (8:407, 1979). We are, of course, all proud that the new specialty of family medicine was the first to require the documentation of continuing medical education efforts, chart audit of our own actual practice, and periodic re-examination to prove continued competency. Any method of logging or documenting our efforts at continuing medical education has to be somewhat tedious and in part arbitrary. However, to have the American Board of Family Practice and the American Academy of Family Physicians use different systems is destructive to the positive attitudes with which most of us approach the process of keeping ourselves current. A refresher course in family medicine may be of value to Dr. Pisacano but for the majority of us who are recently residency trained in family medicine, the refresher course generally is far too superficial or too poorly focused to meet our own perceived specific areas of weakness. It is well documented in the educational literature that different individuals learn better with different types of educational format. To exclude various types of continuing medical education such as Audiotape Digests is to create an impediment to learning for many individuals. I further support Dr. Lawrence's notion that the medical center or the resort hotel is nowhere near as effective a location for training family physicians as are educational approaches that keep the physicians in their practice sites where new information learned can be immediately reinforced by direct patient contact. We need to reinforce the community hospital as a source of continuing medical education rather than to de-emphasize it. Our discipline will be hurt badly if we do not encourage clinicians from the community to remain involved in teaching and if we do not continue to encourage residency trained graduates to think of their own practices as research laboratories for advancing the knowledge and data base of our discipline through publication. These latter two methods of continuing medical education are perhaps the most valuable in that they require active participation, review of the literature, and an attitude of intellectual curiosity. If the Board is concerned that it is impossible to document these experiences adequately, then I would point out that the fact that a physician has paid a tuition fee for a refresher course in family medicine should be of more interest to the Internal Revenue Service than to the American Board of Family Practice. I hope that others feel this way and will join me in encouraging the Board to reconsider its policy before the recertifying process of which we were once so proud becomes an "Ostrich in 1983."

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Emotions and Seizures

To The Editor:

In your January 1979 issue Professor Richard E. Minter asks

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"Can Emotions Precipitate Seizures." Before my year at the US Prison for Women in Alderson, West Virginia, I had heard of people who could bring on grand mal seizures at will. At the prison I met two inmates who confided their ability to have a grand mal seizure at will. One of these proceeded to do so directly before my unbelieving eyes by hyperventilating. Alas, she was not attached to an EEG machine, but her seizure was complete and perfect in all observable respects.

Does this answer Dr. Minter's question?

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Geographic Maldistribution of Physicians

To the Editor:

In his Guest Editorial, "Impact of Family Practice Residency Programs on Geographic Maldistribution of Physicians" (*J Fam Pract 8:461, 1979*), William L. Stewart quoted from the American Academy of Family Physicians 1978 survey, that 52.1 percent of last year's family practice residency graduates settled in communities of less than 25,000 population.[1] This is encouraging data, but not sufficient evidence to suggest, as Stewart has, that the problem "appears to be solving itself" independent of federal intervention.

Slightly older data compiled by the Rural Practice Project show that where the location decisions of young physicians are concerned, small towns and underserved towns are not the same thing. This study—of young (under age 45) physicians who began practice in the nation's 1,730 most rural counties between 1973 and 1976—showed that only 14 percent went to towns where less than two others were already practicing. However, 41 percent of those who were in the US Public Health Service went to these kinds of communities. This is, of course, in keeping with the statutory mandate that National Health Service Corps physicians be assigned only to designated medically underserved areas in order to serve the people *most* affected by the geographic maldistribution.

Communities of less than 25,000 contain more than 55 percent of the nation's population.[2] The rural medically underserved areas to which most NHSC physicians are assigned contain about six percent of the population.[3] I think it is very unlikely that anywhere close to six percent of the family practice residency graduates have gone, are now going, or will go to these areas independent of assignment and support through the NHSC.

When additional data from the survey show that I am wrong, we can believe that the problem may "solve itself" and that the NHSC is no longer needed. (Lists of NHSC assignees and of medically underserved areas are readily available to the AAFP so that identification of these locations and exclusion of NHSC assignees from the survey

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results can easily be made.) But the 1978 survey results as reported permit no such conclusion.

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References

1. Report on Survey of 1978 Graduating Family Practice Residents, reprint No. 155 D. Kansas City, American Academy of Family Physicians, 1978
2. Statistical Abstract of the United States 1978. In Department of Commerce, Bureau of the Census, (Suitland, Md). Government Printing Office, 1978
3. Manpower—A Change in Course. In Bureau of Health Manpower (Bethesda, Md): Annual Report Fiscal 1978. DHEW publication No. (HRA) 79-41. Government Printing Office, 1979

The preceding letter was referred to Dr. Stewart who responds as follows:

Dr. Madison has raised several interesting issues with respect to geographic maldistribution of physicians.

First of all, it is interesting to note that the figure that he chose to quote from my article *(Stewart WL: Impact of family practice residency programs on geographic maldistribution of physicians. J Fam Pract 8:461, 1979)*, was the one with respect to the number of family practice residency graduates locating their practices in communities of 25,000 or less. He chose to ignore the fact that 11.5 percent of 1978 graduates are in practice in communities of less than 2,500 and that an additional 2.6 percent are serving in inner-city low income areas. One wonders why these figures were ignored.

Secondly, Dr. Madison quotes figures in his letter that were obtained for the years between 1973 and 1976, when family practice residencies were graduating relatively few physicians.

Thirdly, it is interesting that Dr. Madison quotes a figure of 41 percent of US Public Health Service physicians serving in the nations most rural counties. I am surprised that it is not an even higher percentage if the US Public Health Service is really assigning physicians where they are needed.

Fourthly, Dr. Madison uses as an argument that graduates of family practice programs are not meeting the needs of rural America the fact that "*most* National Health Service Corps physicians are assigned to areas containing six percent of the population." Further he "thinks that it is very unlikely that anywhere close to six percent of the family practice residents have gone into these areas." It is interesting that he fails to define "most" and he provides no real facts or figures relative to the graduates of family practice residencies practicing in these areas—only opinion. But most importantly of all, he begs the question—How many National Health Service Corps physicians stay in these areas when their two years of obligated service are over? Put another way—Does it make any sense at all to put physicians in an economically nonviable practice setting on a temporary basis?

Finally, nowhere in my article did I state that the NHSC "is no longer needed." I merely disparaged this as the *only or best* solution to the maldistribution problem.

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