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. All letters that reference a recently published Journal article are sent to the original authors for their reply. If no reply is published, the authors have not responded by date of publication. Send letters to Paul M. Fischer, Editor, The Journal of Family Practice, 519 Pleasant Home Rd, Suite A-3, Augusta, GA 30907-3500, or Fax (706) 855-1107.

AMERICA'S MOST IMPORTANT SPECIALTY

To the Editor:

During the 30 years I have devoted to the education and training of family physicians, I have witnessed our struggle for family medicine not only to be recognized and survive but also to grow and develop. While there have been federal subsidies to promote primary care, they have not made a difference because the academic medical community has not given family medicine its due respect and specialists have been remunerated disproportionally in comparison to primary care physicians.

The result is now well known to all. Instead of 50% to 75% of our graduates choosing primary care, it is now less than one-third allopathic and decreasing numbers of osteopathic. Fewer than 33% of all practicing physicians are in primary care when the proportion should exceed 50%.[1,2] When family practice was declared a specialty in 1969, the goal was to have 25% of all graduates in family practice. Since then, we have increased the number of medical schools and physician graduates, but we have never had more than 15% enter the specialty.

Managed care programs have been advocated by many policymakers both in government and within the medical community. Where managed care has been in place for some time, costs have decreased.[3] The value of the primary care physician has increased while the need for the other specialists has decreased. The results have been dramatic in some cases. We are already beginning to see layoffs of specialists in various parts of the country where managed care now dominates the medical marketplace. It is anticipated that this trend will continue over the next 5 years and, as a result, some physicians may not be able to find work. There is a growing movement to develop retraining and education programs to fill the need for physicians in primary care and to utilize this potential resource of medical manpower.

We now have specialists arguing that they provide primary care services. Perhaps they do, if primary care means continuous care of one organ or sex. Although the argument can be made that the definition of primary care should be liberalized to embrace a wider number of the specialties because of the need for more primary care physicians, doing so will not correct the problem. On the other hand, one can also argue that the delivery of comprehensive health care is enhanced when a primary care physician can manage all members of the family. We simply need more family physicians. Family medicine is the only specialty that provides accessible, coordinated, continuous, and comprehensive health care for a community of people and cares for the patient from birth until death regardless of age and of sex.

A well-trained, well-educated, board-certified family physician can competently manage at least 85% of the health and medical care problems a person faces in a lifetime. That makes it possible for such a physician to practice in any geographic area, whether in urban, suburban, semi-rural, or rural America. Of course, that also means they can practice in any remote or underserved area as well. Since the 1950s, every report addressing the issue of physician manpower indicates a need for physicians with this capacity.[4,5] That is what makes family practice America's most important specialty.

Including other specialties in primary care would do little to promote family medicine or affect physician workforce reform. All health care policies should promote the academic and practice environments of family medicine to enable us to train and educate not 25%, but 50% of our graduates into competent, well-compensated family physicians.

Nikitas J. Zervanos, MD
Lancaster, Pennsylvania

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2. Kahn NB, Schmittling G, et al. Results of the 1994 National Resident Matching Program: Family Practice. Fam Med 1994; 26: 487–91.
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4. American Medical Association Report of the Ad Hoc Committee for Family Practice of the Council on Medical Education. Meeting the challenge of family practice. Chicago, Ill: American Medical Association, 1966.
5. Folsom MB, Chairman. Health is a community affair. Report of the National Commission on Community Health Services. Cambridge, Mass: Harvard University Press, 1966.

To the Editor:

I have been outraged by the plans for the "retraining of other specialists for family practice." Family practice is a board-certified specialty with a 3-year residency requirement.

Other specialists need to complete a family practice residency and pass the family practice boards. Credit should then be given for board-certified specialists in their area of expertise *only.*

Any other plans would demean all board-certified family practitioners and send out a hoard of physicians incompetent to practice primary care. Such a development would damage our reputation as family practitioners as well as risk our patients' well-being.

Nayvin Gordon, MD
Oakland, California

ALIEN LIFE FORMS

To the Editor:

Thank goodness Dr Bennett had the courage to speak up regarding his alien child. (*Bennett HJ. My daughter is a Klingon. J Fam Pract 1994; 39:295–6*). Up until now, my husband and I thought we were alone.

At 30 weeks' gestation now, we have had a multitude of ultrasounds. Once she no longer appeared to be a salamander, it became clear from the AP facial views that we, too, had a Klingon daughter. There were no Klingon male donors at the fertility clinic that day, so a semen specimen mix-up does not explain her appearance. Although I admit that Worf's appearance has improved each season, I swear we have never seen each other.

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It is only through thorough and meticulous research on other families in our situation that we will ever be able to explain this. (Are Klingons actually spontaneous mutations of Earthers?)

Nicole A. Chauche, MD
San Diego, California

The preceding letter was forwarded to Dr Bennett, who responds as follows:

I appreciate Dr Chauche's thoughtful response to my article. Although anecdotal reports are important, I agree that they are no substitute for carefully controlled, prospective research. As a start, I suggest we seek answers to the following questions:

- Should all pregnancies be screened for alien life forms?
- What percentage of Klingon fetuses will be picked up on a level-2 sonogram?
- At what age can physicians reliably diagnose a Klingon baby?
- What impact, if any, exists between the use of fertility drugs and giving birth to a Klingon infant?
- Given the choice, would most physicians prefer raising a Klingon, a Vulcan, or a Romulan infant?
- Is the Klingon influence stronger on the West Coast?
- Are Klingon babies equally represented in the general population or do they have a preference for medical families?
- Do most surgeons have Klingon ancestors in their family tree?
- Can I use a Klingon grant to help cover my orphan research projects?
- Should we establish a national clearinghouse for information on extraterrestrial births?

While all of this is being studied, my wife and I are writing a book for the general public. It's called *Klingon Babies and the Parents Who Love Them* (Milky Way Press).

Howard J. Bennett, MD
Washington, DC