

out that we do not know if physicians had asked patients to return after prescribing an antibiotic. There are certainly limitations to the use of medical billing data: (1) we could not measure the severity of a patient's illness, (2) we were unable to capture any information about clinician recommendations for return visits, and (3) we did not collect ICD-9 codes for adverse events, which may be another plausible explanation for a patient returning for follow-up.

However, even given these limitations, we believe several aspects of our study inclusion criteria helped address this issue, particularly for patients seen on the initial visit for a URI (ICD-9 465 and 460). To be classified as a URI for the purposes of our analysis, we excluded cases that were also diagnosed with any other respiratory illness at the time of the visit (such as acute otitis media, sinusitis, or pharyngitis), making it unlikely that they had a severe or complicated illness. We found that patients with acute otitis media, pharyngitis, and URI were more likely to return if they had received antibiotics on the initial visit. Although patients may be asked to return to see if their ear infection has resolved, it is not common practice in the United States to reassess patients with pharyngitis or URI. Thus, we believe that our finding suggesting that receipt of an antibiotic may actually increase return visits is plausible and deserves more study as part of evaluation of programs attempting to limit inappropriate use of antibiotics.

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Low Interest in Geriatrics Training

To the Editor:

The articles and editorial on geriatrics in family medicine education in the November-December 2008 issue of *Family Medicine*

highlighted the low level of interest in geriatric training in family medicine.^{1,2} However, I do not believe that geriatric fellowship training is an accurate gauge of geriatric care interest. Nor do I believe it is necessary for providing quality geriatric care. In fact, such an expectation may be just another reason that more family medicine residents do not see themselves going into geriatric care.

In spite of the low percentage of family physicians with a CAQ in geriatrics (2.8%),² family physicians play an integral role in running many of America's long-term care facilities. A recent survey of nursing home medical directors revealed that only 15% had fellowship training, and a minority, 42%, had a CAQ in geriatrics.³ The same survey found that family physicians comprised 37% of the medical directors. Similarly, the American Medical Directors Association reports that 30% of its members are family physicians (e-mail communication with Marcie O'Reilly, director of Membership and Communications for the American Medical Directors Association, March 10, 2009). As an example, I am a medical director for a long-term care facility but have never done any geriatric fellowship training.

Further, I believe that many of our residency programs do not expose residents to enough of modern geriatric care. I can attest to this, with embarrassment, as a former residency program director. The geriatric curriculum I crafted for my residents was stale. It differed greatly from what I now see as a medical director of a long-term care facility and in my clinical practice. My facility embraces the Eden Alternative, which is an example of the new approach to institutionalized geriatric care. I wish that I had given my former residents this kind of geriatric care experience.

I feel strongly that our specialty benefits from a strong participation

in, and support of, geriatric fellowships. I do not believe, though, that a focus on geriatric fellowship training gives an accurate picture of family medicine's involvement in geriatric care. Let us highlight the positive and substantial role of all family physicians in geriatric care. We should expose our young physicians to what is new and exciting in geriatric medicine. After 15 years of practice, I now "get" geriatric care. It would have been a shame if I had let the lack of a geriatric fellowship deter me from one of the most enjoyable and rewarding aspects of my clinical practice.

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REFERENCES

1. Caprio TV, Karuza J, Katz P. Profile of physicians in the nursing home: time perception and barriers to optimal medical practice. *J Am Med Dir Assoc* 2009;10:93-7.
2. Weiss BD. Geriatrics: in our residents' future whether they know it and like it or not. *Fam Med* 2008;40(10):741-3.
3. Helton MR, Pathman DE. Caring for older patients: current attitudes and future plans of family medicine residents. *Fam Med* 2008; 40(10):707-14.

Author's Reply:

I completely agree with Dr Harrington that completion of a geriatrics fellowship is not an essential step in providing quality medical care for older adults. Lots of family physicians and internists provide excellent care to older adults without having completed a geriatrics fellowship. In my editorial, I only used the low rate of interest in geriatrics fellowships as an example of residents' low interest in geriatrics overall. In the face of the aging American population, there must be something very wrong with the way we teach geriatrics if more residents opt for advanced training in sports medicine than in geriatrics.

So, I also agree with Dr Harrington that we need to do a better job of teaching our residents about how to care for older adults. Nursing homes, dementia units, hospices, and chronic illnesses are

certainly a big part of geriatrics, but care in these areas needs to be provided in new and innovative ways that will be exciting to the generation of young physicians that will provide the care. And, we need to do more to expose our trainees to the vigorous, healthy, older adults who can most benefit from preventive measures to keep them vigorous and healthy. In a world where people in their 90s run marathons—and do so in respectable times—there is no excuse for limiting geriatrics training to nursing homes, hospices, and hospitals.

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New Research

Do MCAT Verbal and MCAT Writing Scores Correlate With Performance on a Third-year OSCE?

To the Editor:

The Medical College Admission Test (MCAT) serves as a benchmark for the admissions process and is a good predictor of preclinical performance and board exam scores.^{1,2} The ability of the MCAT to predict clinical performance is a topic of active debate. There is little evidence that MCAT scores accurately predict effective communication skills in the context of patient care.

Our study examined the relationship between the MCAT verbal and writing sample scores and medical student performance on a validated family medicine objective structured clinical exam (FM-OSCE). We hypothesized that MCAT verbal and writing scores would correlate directly with FM-OSCE scores to provide an objective measure of student communication skills.

Methods

Following institutional board approval from the Uniformed

Table 1
Pearson Product-Moment Correlation Coefficients of FM OSCE Scores and Scores on the Medical College Admissions Test (MCAT) Along With Admission Interview Scores

Component Score	Pearson Correlation
MCAT-V	0.134 ($P<.05$)
MCAT-WS	0.115 ($P<.02$)
Interview Score	-0.55 ($P=NS$)
MCAT-PS	0.068 ($P=NS$)
MCAT-BS	0.044 ($P=NS$)

MCAT-V—verbal
MCAT-WS—writing sample
MCAT-PS—physical science
MCAT-BS—biological science

Services University (USU), we retrospectively examined MCAT verbal, writing, physical science, and biological science scores from the classes of 2006–2008. We also examined subjective verbal communication scores on the USU admissions interview and student scores on the USU FM-OSCE.

MCAT verbal, biological science, and physical science scores were entered from the American Medical College Application Service (AMCAS) data provided on each student's USU application. MCAT writing sample (MCAT-WS) scores were converted from alphabetic scores to a numeric score (0 for J through 10 for T). All data were exported into SPSS® v. 16 for analysis. We used basic descriptive statistics for group characteristics. Pearson's product-moment correlation coefficients were calculated to determine association strength and direction between paired variables. An analysis of power suggested that a sample size of 450 students would have 80% power to detect correlations of at least 0.15 with a 5%, two-sided significance level.

Results

Data were available for 480 USU graduates. The average MCAT verbal score was 9.2 (range 2–13; standard deviation [SD]=1.7). The

average MCAT writing sample score was 6 (range 1 to 10; SD=2.0). The average verbal and communication skills interview score was 2 (range 1 to 5; SD=1.0). There was a statistically significant association between both the MCAT verbal ($r=0.134$; $P<.005$) and MCAT writing sample ($r=0.115$; $P<.02$) scores and performance on the FM-OSCE. There was no association between applicant interview scores ($r=0.064$, $P=NS$), MCAT biological science ($r=.044$, $P=NS$), MCAT physical science ($r=0.068$; $P=NS$) scores and FM-OSCE scores (Table 1).

Discussion

Effective communication is an essential element of clinical success. Patient communication skills are a core professional competency. Poor communication skills correlate directly with poor patient management⁴ and increased patient complaints to regulatory authorities.^{3,5} We found a small, but statistically significant, association between MCAT verbal and writing sample scores and performance on the FM-OSCE. While our effect size is small, the positive correlation between MCAT verbal and writing sample scores and OSCE scores supports a direct relationship between communication skills and