

Letters to the Editor

Joseph Scherger, MD, MPH
Editor, Letters to the Editor Section

Editor's Note: Send letters to the editor to jscherger@ucsd.edu. We publish Letters to the Editor under three categories: "In Response" (letters in response to recently published articles), "New Research" (letters reporting original research), or "Comment" (comments from readers).

In Response

Response to the Murder of George Tiller

To the Editor:

In his September 2009 commentary, "The Murder of George Tiller—Where Is Family Medicine's Response?" Josh Freeman, MD, recognized the important role that George Tiller, MD, played as a family physician in his community, prior to being shot to death in his church on a quiet Sunday morning.¹ Dr Freeman appropriately notes the depth of this tragedy for his family and his patients and how inappropriate the use of violence is in expressing an opinion regarding any issue, even one as controversial as abortion. At the same time, Dr Freeman called into question the fact that no family medicine organization has made a formal statement regarding the murder of Dr Tiller.

As the leadership of STFM, we would like to respond to this particular issue as it relates to our organization. First, it is important to note that Dr Tiller was not, nor had ever been, a member of STFM. While we recognize the death of STFM members in our monthly electronic newsletter *The Messenger*, we do not acknowledge the death of non-STFM members. Just as important, we have chosen to not comment on issues that are not directly related to the education of medical students, residents, or

faculty development. This is true on multiple issues, not just abortion. In fact, STFM has made no official comment on the current health care reform debate except as it relates to medical education issues. While we do not officially comment on such issues, we certainly support dialogue among our members and learners on complicated issues, including the well-being and safety of those who provide training and mentorship in the provision of abortions.

STFM is committed to our mission of advancing family medicine to improve health through our membership. While our sympathies are extended to his family, his patients, and his community, STFM stands behind the decision to not comment as an academic organization on the murder of Dr Tiller.

STFM Executive Committee

Terrence E. Steyer, MD

W. Perry Dickinson, MD

Scott A. Fields, MD, MHA

Alison Dobbie, MD

Ellen Whiting, MEd

Stacy Brungardt, CAE

REFERENCE

1. Freeman J. The murder of George Tiller—where is family medicine's response? *Fam Med* 2009;41(8):589-90.

Prescribing Antibiotics

To the Editor:

Li and coauthors studied antimicrobial prescribing for upper respiratory tract infections and

subsequent return visits.¹ Both the title of their paper and their interpretation of the outcomes suggest that the authors may have misinterpreted correlational data as causal. Their finding that prescribing antibiotics did not result in a decrease of return visits should therefore be interpreted with caution. It may be possible that, in case of an antibiotic prescription, physicians more often ask patients to come back than without such a prescription, for instance to verify whether the prescription has had the planned result. If this alternative interpretation would be valid, the study results may be not as helpful in "dispelling an important myth about patient antibiotic-seeking behavior" as the authors advocate. To reliably assess the effect of antimicrobial prescribing on return visits, the choice of asking the patient to come back should be independent of the prescription.

Johannes C. van der Wouden, PhD

Department of General Practice

University Medical Center Rotterdam

Rotterdam, The Netherlands

REFERENCE

1. Li J, De A, Ketchum K, Fagnan LJ, Haxby DG, Thomas A. Antimicrobial prescribing for upper respiratory infections and its effect on return visits. *Fam Med* 2009;41(3):182-7.

In Reply:

We agree with Dr Van der Wouden that great care should be taken in inferring causation from mere associations. In his comments, Dr Van der Wouden correctly points

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.

John Li, MPH

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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.

Brian C. Harrington, MD, MPH
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Steamboat Springs, CO

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