

Letters to the Editor

In Response

AAFP and Coca-Cola

To the Editor:

Thank you for having the courage to publish the article by Jane Murray, MD, in the January 2010 *Family Medicine* regarding the relationship between Coca-Cola and the AAFP. In a few years, we will reflect on such affiliations with the incredulousness with which we now view yesterday's ads in which doctors encouraged us to smoke Lucky Strikes.

It is somewhat embarrassing for me to call myself a family physician when the AAFP Executive Vice President Doug Henley, MD, states that since the American Dietetic Association says there are no good or bad foods, it must be all right for the AAFP to take money from Coca-Cola. I do not know whether to cry, scream, or drop my membership from AAFP.

I would like to suggest that STFM send our sisters and brothers at AAFP a request to consider returning the money to the Coca-Cola Company. I agree with Dr Murray that best way for those of us in the AAFP to promote health would be to return the Coca-Cola money and not be forever known as health promotion hypocrites.

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Service Learning Is No Substitute for Social Justice

To the Editor:

I am a medical student at the University of Washington School of Medicine and am writing to take issue with the article by Drs Main-

ous and Baker, "Service Learning Helps Sustain the Status Quo," recently published in *Family Medicine*.¹ While it is valid that education on health reform is a dire need for all citizens, least of all medical personnel in training, it is simply inappropriate to lay the failures of our system on service learning. It would be more effective and appropriate to advocate for increased political discourse to complement the service learning requirement, itself a hard-won reform of medical education.

In all areas of injustice there is a need both to care for the wronged and to create structures that eliminate the injustice itself. Ideally the two needs are met in such a way that they reinforce one another and bolster the struggle for justice. It is at times a strategic decision to focus on one area or another, but it is altogether different to presume that one exists to the detriment of the other.

I am only in the first year of my medical training so I would like your opinion on a clinical question. Should you treat an African American child's asthma knowing that the rate of asthma among African American children is 10 times the background rate and largely due to substandard housing? Is it not more appropriate to deal with the substandard housing than clinical treatment, which presumes that this disparity in health will remain? Perhaps it would be more appropriate to deal with the substandard housing that helps drive the disparity. Wouldn't treatment help obscure the larger issue and delude the treating physician into believing they are effective?

I would like to share the response of Ben Danielson, MD, of the Odessa Brown Children's Clinic in Seattle. Dr Danielson would treat

the patient, as is his professional and moreover moral obligation, but he would also address the larger issue. Dr Danielson is the principal on a grant that brings a lawyer into the clinic to advise patients on their rights concerning mold remediation and to serve as their advocate to the landlord. I find this response commendable, even as I, and I believe Dr Danielson, understand that legislature addressing substandard housing or a committee on health equity to vet legislation is more desirable and would prove a longer-lasting solution. I would add that the reason I know Dr Danielson and the reason I am in medical school in the first place is due to the "pipeline strategy" decried in the article by Drs Mainous and Baker.

In closing, while I am disappointed with the article, I strongly agree with the assertion that more political education is necessary in medical school and invite your suggestions on how medical education can be amended to address health care reform, grounded in the experience gained from service learning.

Luis Manriquez

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REFERENCE

1. Mainous AG III, Baker R. Service learning helps sustain the status quo. *Fam Med* 2009;41(9):656-8.

More on Service Learning

To the Editor:

I was pleased to read the essay "Service Learning Helps Sustain the Status Quo" by Mainous and Baker. It makes important points about the need to have structural change in our social and health care systems that deny a large portion of our population (and it would be bad if it was only a small portion!)

their basic human needs, including access to health care. People who volunteer their time and efforts are important, but it can never be expected that this takes the place of a society committed to social justice; similarly private donations cannot take the place of government commitments.

A few examples from our area:

- A few years ago, a new conversion foundation committed to supporting the health needs of the underserved was created. In the same week that it announced that it would give away \$20 million a year for this purpose in Kansas City, the governor of Missouri announced cuts of \$600 million to Medicaid.

- A local branch of an FQHC serving a desperately poor community moved to another area where the higher Medicaid population would allow it to financially survive. A local not-for-profit safety net clinic opened a satellite in that now-unserved community; it survives not only on foundation support but because all its staff, including doctors, dentists, and nurses, work for \$12 an hour.

Our safety net clinics, including the student-run free clinic, provide important services to uninsured people but cannot begin to touch the real need (in addition, as Drs Mainous and Baker point out, to needing access to many services beyond those of primary care physicians).

Martin Luther King, Jr, said “Philanthropy is commendable, but it must not cause the philanthropist to overlook the circumstances of economic injustice which make philanthropy necessary.” More pithily, Jonathan Kozol wrote “Charity isn’t a good substitute for justice.” We can never forget this and never stop fighting for justice. We must teach our students to both provide care for the needy and to work for system change.

It is absolutely appropriate to recruit medical students based on their social conscience and commit-

ment. This is a more valid indicator of being someone who is likely to make a difference in the health of communities than is a 4.0 average in the sciences, something never shown to be correlated with the quality of a physician. We also must provide opportunities for them to do good, foster those acts, and provide role models. And, if we are ever fortunate enough to have universal financial access to health care, they can work on the other social issues that will continue to exist, such as those the authors identify in the United Kingdom. Our profession can never have too many good, caring, empathic people.

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Authors’ Reply:

We are in agreement with many of the points put forward by Mr Manriquez and Dr Freeman. We agree with Mr Manriquez and Dr Freeman that selection of medical students who show altruistic behavior and have a social conscience is desirable. Such students have personal qualities we would like all doctors to possess. We also are in agreement that doctors who provide uncompensated care for individuals who need care should be applauded. But we also agree with the example given by Mr Manriquez and the quotations given by Dr Freeman that show that it is not sufficient to rely on these qualities to ensure access to health care for all those who need it. Nor is it sufficient to reply alone on action by individual doctors to address those factors that cause poor health in uninsured or marginalized groups.

Doctors should not, uniquely, be expected to be charitable. Charity should be expected of all of us, both individually and collectively. Of course medical education should promote and sustain altruistic behavior among future doctors, but it should also encourage students to debate and understand the potential for improving health by collective

action by the societies in which we live.

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Factors That Influence Career Selection Among Medical Students

To the Editor:

We read Morra and colleagues’ recent study on medical students’ perceptions about financial factors and remuneration in family medicine with great interest.¹ Based on a survey of Canadian medical students, this study revealed that a vast majority of the student participants believed that family physicians are paid too little for their services. A majority of the students underestimated the actual income of family physicians compared with physicians in other specialties, such as general surgery and dermatology.

Thirty-seven percent of US seniors graduating from medical schools in 2009 matched in primary care specialties (eg, family medicine, internal medicine, and pediatrics).² This percentage has steadily declined since 2005 (annual average decline of 0.6% from 2005 to 2009); the decline for family medicine is more pronounced with each year (0.1% decline for 2005–2006 versus 0.7% for 2008–2009).² If Morra and colleagues’ findings are extrapolated for US medical students, this continual decline may be attributed in part to student misperceptions about future earnings and opportunity costs of family medicine and other primary care specialties. If students were to consider opportunity costs such as overhead, family life, career satisfaction, work schedule, and flexibility in secondary career options (eg, research, public health, public service), the discrepancy between the average gross income of family