Letters to the Editor

This point system was developed inside the larger context of the Family Medicine Review Committee requirements mandating resident scholarly activity. Is required scholarly activity realistic and clinically useful? Might it leave some residents frustrated and resentful? While we should find ways to foster resident interest in research, mandated participation may not accomplish the desired goal of there being more research in family medicine. Thus, we question the existence of a scholarly requirement for residents in all programs, as it may even be counter-productive.

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Authors’ Reply:

We thank Drs Karuppiah and Wilson for the points that they raise in response to our “Scholarly Activity Points System.” We strongly agree that there are many barriers to encouraging resident scholarly activity. These barriers are, in fact, the reason why the point system was devised.

Drs Karuppiah and Wilson voice a common concern that encouraging scholarship may leave residents frustrated and resentful. Residents certainly have varying levels of interest in research. We have addressed this issue by acknowledg-

ing first, the importance of other forms of scholarly activity, and second, by offering a variety of options. Although the point system is intentionally weighted toward research, many of our residents have successfully met their graduation requirement of 10 points without being involved in any research.

Drs Karuppiah and Wilson also raise the fact that many residency programs do not currently have faculty that possess sufficient scholarly experience. We readily acknowledge that programs with less faculty experience will have a harder time promoting resident scholarship. On the other hand, if a lack of experienced faculty is used as an excuse to neglect resident scholarship, the next generation of faculty will also be inexperienced. Each family medicine program must promote resident scholarship now to build the collective knowledge necessary to mentor the next generation of family physicians. If we do not do this, the status quo will prevail. The Scholarly Activity Point System represents just one possible way to overcome this cycle of inertia.

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Comment

Physicians, Patients, and Society: A Long and Complex History

To the Editor:

The relationship between physicians, individual patients, and society has a long history. Greek Hippocratic doctors were, already in the 5th and 4th centuries BC, health professionals who earned their living through their medical profession and professionalism. When the first Greek physicians arrived in Rome (3rd century BC), however, they were seen quite negatively by great Roman personages, including Cato the Censor. Cato the Censor (3rd and 2nd centuries BC) thought that Greek physicians were out of control and dangerous for Roman society. According to Pliny the Elder (1st century AD) “medicine” was important for the health and well-being of Romans, but “physicians,” by this meaning Greek physicians, were not so important. In effect Pliny the Elder, still in the 1st century after Christ, could not conceive that professional health operators should profit from the diseases of others. Cornelius Celsus (1st century BC, 1st century AD) advised doctors to be cautious and not to touch what they could not heal, suggesting that they should accurately inform patients, in the case of strong medical doubts and fears, that great expectations with regard to eventual prognosis would not be appropriate.

In the Western world, it was in the Middle Ages that, after the establishment of universities and medical faculties, the figure of physicians with a specific degree appeared. Medical faculties spread in Europe in the 12th–13th centuries, and in 1258 a Capitulary of Physicians was promulgated in Venice, so as to fix a set of deontological rules governing the medical profession. In the late Middle Ages, the role of the medical profession became more definite, and in the course of the 14th century different colleges of physicians were constituted, with the task of regulating the granting of licences, given that the medical class wanted to guarantee its profile in the face of public opinion. In this period, the previously defined “medicus amicus” (the physician friend), whose characteristics were to be humanity, reliability, and kindness, was flanked, also thanks to the Royal College of Physicians, by the “medicus gratiosus” (the cultivated physician), a learned and discreet professional able to interact...
tactfully with single patients and with the society as a whole.²,⁴

In recent times, the relationship of physicians with society has become more complex and demanding, so that modern physicians need to add, to the characteristics of their predecessors (the medicus amicus and the medicus gratiosus), an enhanced communicational competence to treat effectively ever more informed and exacting patients.³,⁵

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The Role of a Rural Medical School Campus in Developing a Sense of Place: The First 10 Years

To the Editor:

Most medical schools are now increasing class size and/or starting regional campuses to address the anticipated physician shortage. Maldistribution is also an issue, with only 9% of physicians practicing in rural areas where 20% of Americans live.¹ Previous studies have shown that rural upbringing and small-town medical training are associated with rural practice.²

These issues are particularly acute for Kentucky, since 80 of the 120 counties are considered underserved. In 1998, the rural Trover Campus (ULTC) began as a regional campus of the University of Louisville School of Medicine (ULSOM) to address the need for rural physicians for Kentucky. The ULTC campus is in Madisonville, a town of 20,000 that is 150 miles southwest of Louisville. After completing their first 2 years at the Louisville campus, up to 12 students per year move to Madisonville to complete all of the required clinical rotations. The same didactics (by Interactive Television), curriculum, and evaluation methods are used for both campuses. The first ULTC LCME review was in 2005, and the ULTC was listed as one of the 10 strengths of the ULSOM in their report.

The early years of the campus required the students to interview and make a choice to move during their M-2 year. Despite almost 25 M-2s showing interest each year, only two to six students per year made this choice, resulting in a careful survey of those who did and did not choose to move to help us understand the process. The results showed that it was social, not academic, issues that were responsible.³ The largest effect was the students’ desire to be close to home, and the majority of the students were from central or eastern Kentucky, 200–300 miles from Madisonville. The unifying concept was one described earlier in Kentucky by the demographer Cutchin.⁴ He used the term “sense of place” to describe Kentuckians’ ties to land and family as the matrix for their finding of meaning in rural practice.

With this concept as a guide, we set out to facilitate medical school admission for more students from western Kentucky. The effort began with a High School Rural Scholar program, then a college Trover Rural Scholar program, then summer programs in Madisonville before and after the M-1 year, and lastly a Rural Medicine Elective taught in Louisville during the academic year. We worked closely with the ULSOM Admissions Committee to help them accomplish their stated goal of admitting more rural students. This resulted in 2006 in a ULTC dedicated admissions process. Students at the time of application to medical school now specify which of the two campuses they prefer for the clinical years, and those who indicate Madisonville subsequently interview both there and in Louisville. Trover staff are ex-officio members of the Admissions Committee and actively advocate for qualified rural applicants.

These efforts have resulted in the ULTC being oversubscribed, with 15–20 admitted students each year indicating preference for Madisonville, necessitating planning to increase class size. The goal of producing more primary care physicians and rural practitioners has also begun to be accomplished. During a time when the national average choosing family medicine was 8%–10%, 21 of 41 ULTC graduates (51%) made this choice, with 15 choosing another primary care residency, for a total of 88% in primary care. Of the graduates settled into practice, 16 of the 23 (70%) are in rural practice.

The first 10 years of these efforts show that establishing a regional campus in a very small town is possible and that attempts to get the right students in the right place can heighten their sense of place.

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