Letters to the Editor

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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

Family Medicine Is Alive at Columbia

To the Editor:

We were surprised to see that there is no family medicine administrative structure at Columbia College of Physicians and Surgeons according to the table that ranks medical schools based on their 3-year percentage of graduates who were family medicine residents.1 The 2008 and 2007 Match results articles in Family Medicine identified the Columbia Center for Family and Community Medicine as a center.2,3 Our administrative structure is still here at Columbia, and our status has not changed.

Rank lists have a certain appeal. Columbia has a long way to go before we can aspire to have the best record for a medical school without a department of family medicine. Hopeful green shoots at Columbia include an active, growing student interest group, innovative community service projects,4 and a primary care clerkship that has significant family medicine leadership and teaching.5 We have an independent clinical service and residency program at the New York Presbyterian Hospital, Columbia’s primary teaching affiliate. We are collaborating to develop a practice-based research network6 and building promising new connections to the Community Engagement Resource of Columbia’s Irving Institute for Clinical and Translational Research—our CTSA. We write to let the academic family medicine community know we are alive and well and promoting the family medicine workforce that is so critical to the future of our nation’s health.

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References


A Point System for Resident Scholarly Activity

To the Editor:

Drs Seehusen, Asplund, and Friedman are to be commended for their innovation in family medicine education by creating a point system for resident scholarly activity.1 Other family medicine residency programs across the country are struggling to get residents to fulfill the strict ACGME program requirements.2 Few community programs have the luxury of having faculty with research experience or publications.4,5 We question the applicability of the 10-point grading system in smaller family medicine residency programs without previous research experience or faculty with research experience.

The point system strongly favors the completion of an IRB-approved research project or a well-conducted quality improvement project.1 This system may work at the 18-resident US Army family medicine program, which has a program director and other faculty who publish often as well as a track record of research and scholarly activity.3 It might be hard to replicate this specific point system in other residency programs.
This point system was developed inside the larger context of the Family Medicine Review Committee requirements mandating resident scholarly activity.\textsuperscript{2} 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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\section*{References}
5. Carek PJ, Mainous AG III. The state of resident research in family medicine: small but growing. Ann Fam Med 2008;6:52-54

\section*{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-

\section*{Comment}

\textbf{Physicians, Patients, and Society: A Long and Complex History}

\section*{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.\textsuperscript{1} 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.\textsuperscript{2}

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.\textsuperscript{3} In the late Middle Ages, the role of the medical profession became more definitive, 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