Future research needs to target broader sampling so there can be more insights into this population.

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Re: A Successful Walk-In Psychiatric Model for Integrated Care

To the Editor: The Kroll et al[1] walk-in model for sustained psychiatric care was able to increase follow-up encounters, especially in vulnerable populations. The authors claim "waiting room time was usually shorter in the afternoon;" however, they did not thoroughly measure it.[1] A primary or integrated care practice that serves these at risk groups may hesitate to use this model because of the fear of its effects on wait time.

Wait time and total time in office or clinic have a significant effect on patient satisfaction.[2] Satisfaction is time limited, noted by the existence of a "golden hour" patients are willing to wait for a medical encounter.[3] Positive satisfaction correlates with "improved medication adherence" in patients with mental health conditions.[4] Practices may worry patient dissatisfaction could be exacerbated by unknown wait times in a patient population that is already prone to poor adherence and return visits as the authors recognize.

Failing to rigorously measure waiting room time limits the generalizability and applicability of this model. With the risk of patient dissatisfaction and worsened outcomes, practices may hesitate trying this model and will then miss out on its benefits of increased patient followup. Future research in this area should include rigorous measure of wait time to encourage uptake of this promising walk-in psychiatric model.

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Response: Re: A Successful Walk-In Psychiatric Model for Integrated Care

To the Editor: Dr. Brinn[1] is right to point out that that the walk-in psychiatry model we developed at Brigham Health[2] fails to manage waiting room times in a way that proactively engages patients who might otherwise leave before receiving treatment. A trade-off was made between risking all the pitfalls that Dr. Brinn described and the potential consequences of prolonging lag times for a scheduled appointment in a traditional model, including a higher risk of missing that appointment,[3] decreased patient satisfaction,[3] and in some cases a higher mortality risk.[4] Neither model is so seamless that it works well enough for all patients, and measuring and reducing wait times is the right next step.

It is a shame that most health systems have been so slow to adapt to the waiting time problem when other industries figured it out long ago. Restaurants that do not take advance reservations find a variety of ways to keep prospective diners occupied until their tables are ready or else they would leave. We sometimes send

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our
patients to lunch. Haircutting chains have smartphone apps that allow prearrival check-ins. We do not. Some fashionable places still have a line that snakes around the block on most nights, in which people wait hours for something they believe they cannot do without. Our clinic is not that fashionable, and our patients deserve better service, but people have been willing to wait because they need what we offer, and they have nowhere else to go.

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That Clock is Really Big

To the Editor: This year, rather than recertifying my diplomat status as I have in the past by sitting for the recertification examination, I am participating in the American Board of Family Medicine (ABFM) longitudinal pilot recertification test. The ABFM is experimenting with allowing diplomates to take 25 questions every 3 months rather than sit for a day long recertification test. This iteration is an example of the ABFM incorporating best pedagogical practices, which excites my educator heart. Test-takers are permitted to use sources and 5 minutes per question. During the first iteration of these 25 questions, I struggled mightily as the clock was quite large and the countdown numbers changed every second, literally (eg, 5:00, 4:59, 4:58). It was excruciating. I have never had test-taking anxiety, but this technology aspect threw me. My prior experience with diplomat testing included 1 article, scantron rendition, and 1 computerized rendition. I had adjusted to the computer and the inability to circle keywords in the question, despite appreciating article and pencil. The moving, oversized clock led to my missing the first 5 questions; I was completely unable to access my knowledge or various on-line resources. Finally, I covered the clock so that I could not see it and started to get questions correct. I found my rhythm. I focused and put serious energy into not looking at the giant moving clock on the screen. I submitted my concerns about the gargantuan clock after I completed the testing.

I was filled with relief and gratitude when I took the next quarter's 25-question set months later and found that the giant clock was reduced in size and moved to the top of the screen. I had logged on ready with a clock strategy (covering the clock with a Post-it note). With the clock dethroned, I found my rhythm immediately. I am grateful as an educator for this experience; this reminds me that every learner, including patients, all have their own metaphoric moving, giant clocks. I am also grateful to the ABFM for hearing me and others who gave feedback about the challenges of the clock.

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Re: New Allopathic Medical Schools Train Fewer Family Physicians than Older Ones

To the Editor: Despite years of recommendations for correcting the shortage of primary care physicians, the struggle to coax students into primary care remains.[1,2] Creation of new medical schools has not been the answer, as reported by Beachler et al.[3] Drowos[4] wisely calls on leaders to consider why certain medical schools "are successful at recruiting medical students into family medicine…"; We think we know—it is more about mission and culture than strategy.

The University of Alabama's College of Community Health Sciences (CCHS) has provided clinical year medical education as the Tuscaloosa Regional Campus (TRC) of the University of Alabama School of Medicine (UASOM) since 1972. Founding Dean, William R. Willard, MD, of the "Willard Report,"[5] shaped the College in response to a desperate call for family physicians, infusing a deeply held sense of mission from which we have not strayed.

Many medical schools report optimistic though misleading data on its graduates' match into primary care,[6] failing to adjust for the attrition of up to 80% of residents into subspecialties, particularly in internal medicine and pediatrics.[7] What distinguishes our data are that we have been able to track all 850 UASOM graduates who trained at the TRC over 4 decades to verify their practice location and specialty.

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