We will try to publish authors' responses in the same edition with readers' comments. Time constraints might prevent this in some cases. The problem is compounded in a bimonthly journal where continuity of comment and redress are difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Family Medicine in the Middle East

To the Editor: We have read with interest the article by Dr. A. Abyad in the July-August issue of the *JABFP*.[1] Dr. Abyad's article omits important facts and barely reflects the current state of family medicine in the Middle East:

1. Of the 35 references, only 7 were published after 1989. Of these 7 references, 1 is a book (reference 28), 2 are on general family medicine (references 31 and 32), 2 are by Dr. Abyad on the same topic differently presented (references 17 and 18), and only 2 are recent reviews (references 27 and 30).

2. The Arab Board of Family & Community Medicine, which accredits family medicine training programs and administers a family medicine certifying examination, is not mentioned at all. Most Arab countries use the resources and criteria set by this board to help start family medicine training programs. The first program accredited by this board was the Bahrain program in 1989, and next was the American University of Beirut (AUB) program. The first family medicine certifying examination was administered in Bahrain in 1990.[2]

3. There is no rationale why one country's experiences were listed and others were omitted. Egypt, the largest Arab country in the Middle East with the largest number of physicians and medical schools, was not even mentioned. The criteria for selection of which countries to include were not clarified anywhere.

4. Saudi Arabia has more Arab board-accredited family medicine training programs than any Arab country.[2] Dr. Abyad did not mention this fact, nor did he describe how the Saudi primary health care system is organized or how the new family medicine graduates fit into it.

5. Dr. Abyad reported that the Bahrain Residency Program affiliated with the AUB in 1979 because the Arabian Gulf University (AGU) "lacked the academic staff and a defined structure to start a residency program." He also claimed that a joint AUB-AGU committee evaluated the program yearly. AGU did not even exist in 1979; the agreement was between the Ministry of Health of Bahrain and AUB. The decision to establish AGU was announced on 1 April 1980, and it officially started in 1984-1985.[3] AGU had nothing to do with the affiliation between AUB and the Bahrain Residency Program, and there has never been any joint medical education committee between AUB and AGU.

6. The Family Clinic described in Libya is basically a maternal child health clinic with family folders. The Arab Board of Family & Community Medicine commissioned one of us (GH) to visit this clinic in 1989 and make recommendations on how to convert it into a family medicine training center. The references Dr. Abyad uses about Libya's experience with family medicine (references 33, 34, and 35) go back to 1979, 1985, and 1987, respectively, and do not reflect the current status of family medicine in that country.

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The above letter was referred to the author of the article in question, who offers the following reply.

To the Editor: In response to the comments by Drs. Khogali and Hamadeh concerning my recent article "Family Medicine in the Middle East: Reflections on the Experiences of Several Countries," I offer the following responses:

There is nothing wrong with having old references if there are no current references on the topic.

My paper does not claim that it covers all aspects of family medicine in the Middle East; it is only a reflection on different experiences. The Arab Board of Family & Community Medicine was mentioned briefly in the paper. It is important to stress that the first examination carried out by the Arab Board was in 1993; therefore, most of the early programs did not initially have access to or did not use the resources of the Arab Board. Both the AUB and Bahrain programs initially had help from the United States. Professor Vincent Hunt acted as coordinator of the Family Practice Residency Program, with the Ministry of Health in Bahrain, and was Adjunct Professor, Faculty of Health Sciences, American University of Beirut for 1 year.[1]

The Kuwaiti programs are strongly modeled after those of the Royal College of General Practitioners (RCGP) in England. A number of 2-week courses were

taught by United Kingdom (UK) tutors either in England or Kuwait. In 1987 the first diploma examination took place under the direct supervision of the RCGP in the UK. The qualification was known as the Diploma in Family Practice (RCGP/Kuwait). A number of programs in the Arabic region modified their programs to satisfy the Arab Board requirement for certification. I strongly believe that both the American model and the English model had initiating roles in the development of family medicine in the Middle East, with the Arab Board coming only recently as an accreditation and certifying agent.

The Royal College of General Practitioners has established contact with different countries in the Middle East.[2] Contact with Israel, started in 1960, was strengthened by the 12th World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians conference (WONCA), which was held in Jerusalem.[2] Since 1978 the college has made important contributions to the training of Egyptian physicians through Guy's Hospital Medical School.[3] The RCGP/Kuwait fellowship program, started in 1980, proved to be very successful in developing general practice in Kuwait.[4] There are similar links in Saudi Arabia and Bahrain.[2] A number of authors consider Egypt to be part of the African movement of family medicine.[5,6]

In a recent paper[5] on the development of family practice around the world, the authors stated that "in the Middle East, vocational training for generalists is well established in Israel, the American University of Beirut, and Bahrain."[5] They added that "postgraduate training programs are functioning in Saudi Arabia, Kuwait, Oman, and most recently, in Jordan."[5]

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3. Turner RM: Primary care in Egypt. Update 1985;30:476-82.
4. Fraser R. Developing family practice in Kuwait. RCGP News 1989;4:4-5.
5. Haq C, Ventres W, Hunt V, et al. Where there is no family doctor: the development of family practice around the world. Acad Med 1995;70:370-80.
6. Hunt V. The unifying principles of family medicine: a historical perspective. Rhode Island Medicine 1993;76:351-60.

Changing Role of the Family Physician

To the Editor: The recent article by Dr. James Jones (The changing role of the family physician—nirvana or Waterloo? J Am Board Fam Pract 1996;9:442-7) represents about as complete and profound a misreading of our present situation in family medicine as I can imagine. To suggest that managed care is ushering us toward nirvana simply makes no sense at all to physicians involved in the day-to-day struggle with health maintenance organizations (HMOs).

Jones states that "managed care executives...[are] turning to primary care as the champion of the emerging system of health care reform." Dr. Jones, these executives are not "turning to" us; they are exploiting us. We are not "champions" but pawns. Furthermore, whatever you and I might conceive of as "health care reform" (universal coverage, increased access to care for the poor or for people in rural areas) are not concepts that enter into the equations of managed care managers. Their profits derive not from health care reform, but from health care denial.

Jones makes several other statements that strike me as hopelessly naive. He believes that "the political cold war between family practice and other disciplines is just about ended," that "managed care companies are offering two- or three-fold increases in income" to us, and that "now we have reached the pinnacle of our success." Indications of such rosy events are noticeably absent from my office.

I wish that Dr. Jones could have been present in my office while we tried for 7 hours to obtain permission from HMO clerks for a computed tomographic scan for a patient of mine with lung cancer. Or that he could have been sitting in my waiting room when an HMO patient called my receptionist a bitch because a referral that he wanted was not yet ready.

I enjoyed Jones's analogies of Waterloo and nirvana; however, I think that he got them reversed. What we are heading for is not nirvana, but Waterloo.

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Family Physicians and Emergency Care

To the Editor: The recent article by Dr. Jones[1] on the changing role of family physicians illustrates an important aspect of family medicine that needs to be explored in more detail. Family physicians have always provided high-quality emergency care, but our role in this area has not been adequately addressed.[2-4] Many of the trends that Dr. Jones describes, such as access and cost of health care, directly apply to emergency care and need to be considered in cooperation with other specialties. Because family physicians might have an expanded role in providing emergency care as health care delivery systems change, we need to work with emergency medicine organizations to address these issues.[5]

Emergency departments are the "safety net of the health care" system, especially for the uninsured and underinsured.[6] Recent analyses refute the widely held notion that emergency care is "expensive care,"[7] and reinforce that emergency departments are an essential component of an integrated health care system. As the role of the family physician evolves, there are unique opportunities for family physicians to contribute to health policy discussions about emergency medicine.