ing raped by agents who arranged their passage.

We wholeheartedly agree with Dr. Ackerman that ongoing clinical trials are needed. In addition, we believe it is critically important to determine costs of care and mechanisms of reimbursement. The costs of not caring for refugees could outweigh resources spent on detecting illness and preventing complications.

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The Doctor, the Patient, and the Home

To the Editor: Ian R. McWhinney[1] points out the value of caring for patients in their homes, both to them and to their physicians, who thereby get to know their patients better. Dr. McWhinney's article deals mainly with the elderly and dying. There is another time in people's lives when being at home can be an important emotional and spiritual experience: the time of giving birth. Recent reports from the United States, England, the Netherlands, and Switzerland[2-5] again show that home birth can be a safe option for well-selected patients. Most home births in the United States are attended by midwives, but most physicians who attend home birth are family physicians. The climate of fear that surrounds home birth, at least among physicians, has never been supported by evidence of increased risk. Will the time come when this subject can be looked at dispassionately? Our patients will be better served if it does.

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Training Residents to Care for Handicapped Patients

To the Editor: I would like to commend Goodenough and Hole-Goodenough for their article regarding residency training in the care of mentally handicapped patients.[1] The authors highlight the importance of training our future family physicians on caring for persons with mental handicaps. I would also like to emphasize the importance of family physician involvement with disabled patients and their families. This care can be of special benefit to more than 2.9 million children in the United States with disabilities.[2]

Family physicians are in an ideal position to care for these children and their families, whose population is increasing as a result of increased survivability. These families need primary care providers who are able to address the needs of the family as a whole and who can provide continuity as these children move into adulthood. The families with exceptional children often are not looking for an expert on their child's disability; rather, they want someone who knows their family and who knows what resources are available for their child.[3]

As the authors eloquently stated, many family physicians are not provided with the training needed to understand how to use such resources as respite care, parent support groups, early intervention services, and school special education services. Our residency has a unique family practice-based Developmental Disabilities Continuity Clinic, which involves residents in researching resources, interacting with our local special education system, and providing on-going support to these families. Although some of this training can be supplemented by community service in areas such as Special Olympics and at specialized camps for children with disabilities; the importance of further developing our family practice faculty in this area cannot be overemphasized.

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