valuable in managing patients with multiple medical illnesses.

We urge caution with respect to patients in his category two, those presenting with "nebulous" complaints or "not easily categorized by organ system." These patients often suffer from a somatoform disorder.[3] Family dynamic issues play a significant role in these situations.[4] This is not to say that the physician can attribute such problems to a psychosomatic disorder without thoughtful consideration and appropriate evaluation. Physicians in all disciplines, however, have fostered somatoform disorders in some of their patients because they did not recognize the characteristics in these patients and families. Family practice residencies require behavioral science training, and residents obtain fairly extensive education in the field.[5(p 25-6)] This is not true of internal medicine training programs.[5(p 42-3)] The family physician also enjoys the added advantage of caring for the entire family. We therefore believe the residency-trained family physician is better equipped to recognize, appropriately evaluate, and manage such patients in an efficient, cost-effective manner.

We agree that an option for using a general internist exists in the care of patients Dr. Heiligman describes in category three. We would note, however, that family physicians and other generalists are quite good at choosing between aggressive and less aggressive subspecialists, depending upon the approach indicated.

Regarding the patient for whom three or four different subspecialists might be required, we agree that it may be more prudent to consult a broadly trained, well-versed consultant. Too many physicians can be confusing to the patient. When several consultants are required, we believe it is extremely important for the family physician to serve as the "captain of the ship" in directing the evaluation and management and to serve as the primary communicator, educator, and advocate for the patient and family.

General internists should continue to be trained. Those who go on to practice general internal medicine help fill the need in primary care. As noted in our article, however, the majority of internists subspecialize[6] adding to an increasing overabundance of subspecialists and doing little to help the primary care shortage. On the other hand, of the 21,816 graduates of family practice residencies, 93.5 percent are providing direct patient care.[7] In this time of need for primary care physicians, doesn't it make sense to train physicians who will practice primary care medicine?

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Adoption

To the Editor: I am responding to the two-part article[1-2] on adoption (January-March 1988 and April-June 1988) and to the letter[3] on adoption (July-September 1988). I applaud the editorial decision to deal with this often forgotten and ignored issue that has a major impact on family life, and I was pleased with the overall content of the articles.

As a family physician and adoptee, I believe that the manner in which physicians deal with the issue of adoption and with the persons involved in the adoption triad (birthparents, adoptive parents, and adoptees) can set the stage for improved adjustment to the realities of identity and development that arise for each of the parties. The Melinas have stated the point very well on the need for sensitivity and concern on the part of physicians dealing with these matters. However, being well-meaning is not enough. Physicians need to be knowledgeable about expected emotional reactions by triad members, who may be emotionally labile depending on the maturity level and stage of resolution of the different issues involving them. Providing emotional

support could take more time, energy, and expertise than most busy physicians can provide.

For these reasons I believe the Melinas to be somewhat remiss in omitting the idea of support groups for the members of the adoption triad. Although they mention a support group for the adoptive parents, this is only in the case of infertility. I do not believe that all adoptive parents choose adoption because of infertility, although this is a sub-group of adoptive parents, and probably the largest one. I have also found in my own experience that many agencies are strapped by understaffing and lack of financial support, and even the most well-meaning staff members are often unable to provide consistent, ongoing support to triad members. The adoptee is the one most often left out. The point here is that the busy physician can provide a useful service by referring the triad member to a recognized support group.

Finally, in response to Dr. Brassel's idea that not informing adoptees of their adopted status is acceptable and should be standard practice, I register my vehement opposition. His contention that adoptees do not need to know, or that this information is so negative that they should not be told unless medical reasons necessitate it, is absurd and goes against the volumes of literature that persuasively show that adoptees have not only a need to know, but a *right* to know. Many states are considering laws that would now allow adoptees at the age of majority some access to information about their genetic and social background. From an adoptee's viewpoint, this legislation is long overdue. The real issue is not whether to tell a child, but how and when to tell. My own belief is that the manner in which a child is told, and the way a truly loving family handles this information, can make the child feel loved in a special way without making any judgments about the birthparents' decisions.

I also think that the families who have conflicts about adoption convey those negative feelings to their adoptees, who then incorporate low self-esteem and self-doubt into their psyches, often for life. Trying to hide, or lying about, the truth of an adoptee's origin is a negative dynamic that may be destructive when perpetuated in a family. In fact, "keeping secrets" is recognized as an important characteristic of dysfunctional families. This suffering, which can be prevented, argues for meticulous screening of mature adoptive parents who will encourage open discussion of these issues and provide for the self-esteem needs of their adopted children. Adoption does not have to be a disadvantage for a happy life.

Ignorance is *not* bliss in the adoption triad.

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Liberal Education for Family Practice

To the Editor: I was particularly interested in comments you made in your editorial in Vol. 1, No. 4, 1988, about communication skills.

One of my greatest personal peeves has to do with the deterioration and abuse of the English language. This pertains not just to physicians but also to professional broadcasters who, more than anyone, should be experts with our spoken language.

I might add, at least from my personal experience at the University of Texas, Austin, that part of the problem also stems from the system whereby premedical students get their counseling. When I was a microbiology major, irrespective of my goal of medical education, my adviser was, of course, a microbiology professor. Though he was a good man, and very helpful in many ways (including my letter of recommendation for medical school), his personal bias was centered on my field of study for my science major.

I enjoy, and try to read regularly, this new and much-needed journal that you have helped develop. Keep up the good work!

Jon Peterson, M.D.
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Writing about Writing, Part II

To the Editor: I found your copyediting article (October-December 1988) interesting and informative. However, I fear you have sacrificed grammar on the altar of sexless language when you pair a single subject with a plural possessive pronoun in the sentence: *Each patient* was taught to monitor *their* glucose levels daily.

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