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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To see this article online, please go to: http://jabfm.org/content/33/1/155.full.

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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.

Some 440 graduates (52%) who trained at the TRC between 1974 and 2015 matched into primary care fields. Of these, 345 (47%) practiced primary care for a "retention in primary care" rate of 78%. Retention was highest for those who trained in Family Medicine (98%), followed by Pediatrics (71%), Internal Medicine (62%), then Internal Medicine/Pediatrics (36%). This is the highest retention rate for the 3 campuses of UASOM, which trained students during this time frame (Birmingham rate, 45%; Huntsville rate, 52%). Of note, retention rates for General Internal Medicine (TRC, 62%; Birmingham, 29%; Huntsville, 24%), and for General Pediatrics (TRC, 71%; Birmingham, 59%; Huntsville, 52%), suggests a broad effect that is not specialty specific.

The authors have experienced this sense of mission over our own 40 years of personal history with CCHS. The majority of CCHS deans have been primary care physicians; graduate medical education at CCHS is limited to Family Medicine; research is focused on community and rural issues and prematriculation, rural and minority pipeline programs emphasize primary care and service to rural communities. Learners have the breadth, role, ability and collaborative style of the generalist reinforced as they work with all CCHS faculty of all specialties.

The late management sage, Peter Drucker, is said to have articulated that culture eats strategy for breakfast. Forty years of data from one of the country's older regional campuses supports that notion.

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The above letter was referred to the authors of the article in question, who declined to respond.