

hassle factor is high." I for one do not refuse to see nursing home patients, especially those for whom I have cared for in the past. I simply choose not to see them *in the nursing home*, for to do so would add to my bureaucratic burden. I will see them in the office, at the hospital, or even at home; I suspect that many of those family physicians castigated by Dr. Waltman practice the same way.

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1. Waltman R. Sorry, I don't see nursing home patients. *J Am Board Fam Pract* 1992; 5:104-6.

Success Strategies

To the Editor: While I applaud Taylor et al.'s article¹ as a primer for family medicine department heads, I am concerned about the implicit messages it sends to the rest of us: institutional acceptance has replaced institutional change as the desired ideal of family medicine in academia. The article suggests that success in family medicine is measured solely by the traditional criteria of medical schools.

In 1973 Ransom and Vandervoort warned us that family practice and family medicine were moving to accept "the values and biases of an overly specialist-dominated, outmoded system rather than the realities of the primary health care needs of this nation and the challenge of doing things differently."² p 1100 The times have certainly changed, but reading Taylor et al., I believe that Ransom and Vandervoort's statement rings true 20 years later. Vast numbers of people still lack access to medical care,³ and medical costs skyrocket⁴ at the same time students choose to enter high-technology specialties.⁵ Medical schools, according to Relman in a previous edition of this journal, continue to produce physicians who, "however technically competent they may be, simply don't feel comfortable . . . , or are not interested, or are afraid of relating to their patients as human beings."⁶ p 50S

Clinician-educators in family medicine can and should pursue novel and atypical solutions to these problems, and they should be applauded for these efforts. They should not assume that family medicine has fulfilled its role as a change agent in medical education. They should strive to make family medicine's designation as the academic counterculture a reality rather than a casual reference.

The challenge is difficult for those now training students and residents: to balance integration *and* innovation in filling the many scholarly niches of family medicine in the 1990s and beyond.

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2. Ransom DC, Vandervoort HE. The development of family medicine: problematic trends. *JAMA* 1973; 225:1098-102.
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4. Woolhandler S, Himmelstein DU. Resolving the cost/access conflict: the case for a national health program. *J Gen Intern Med* 1989; 4:54-60.
5. Babbott D, Baldwin DC, Killian CD, Weaver SO. Trends in evolution of specialty choice: comparison of US medical school graduates in 1983 and 1987. *JAMA* 1989; 261:2367-73.
6. Relman AS. What medical graduates need to know but don't learn in medical school. *J Am Board Fam Pract* 1990; 3:49S-53S.

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

To the Editor: I thank Dr. Ventres for his interest in the article "Success Strategies for Departments of Family Medicine." I am concerned, however, that Dr. Ventres has inferred a conclusion not intended by the authors, that: "the article suggests that success in family medicine is measured solely by the traditional criteria of medical schools."

I concur with Dr. Ventres: family medicine has an important role in the medical school that includes introducing family practice values and concepts into a highly specialized, often medically fragmented, environment. A medical school department of family medicine, however, cannot effect change in the curriculum or in patient care based upon claims of moral superiority or even public support. Instead, the family medicine department can fulfill its role as a change agent only after its faculty members gain respect in the academic medical center as outstanding clinicians, innovative educators, and productive researchers.

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