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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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.

Dr. William MacMillan Rodney, who is described by Dr. Jones as a "defender of comprehensiveness" and "another of my heroes," has been an advocate for the role of family physicians in emergency medicine. He has described family medicine and emergency medicine as "the only true generalist specialties," since they see all patients regardless of age, sex, or organ systems.[10] His program at the University of Tennessee for additional training of family physicians in emergency medicine provides a model that should be emulated.

Nevertheless, the increasing hiring bias against family physicians in emergency medicine might be our Waterloo. Although family physicians provide high-quality care in many emergency departments and might be the only emergency physicians available in rural areas,[11] certification by the American Board of Emergency Medicine (ABEM) has been used as the standard of competence even though less than 50 percent of emergency physicians are certified by ABEM.[12] Since 1988, family physicians have not had access to this examination despite a special pathway for academic internists. Even though family physicians helped start the specialty of emergency medicine and continue to provide essential emergency care, there has been little professional support for family physicians in this area.[13]

Because patients cannot choose their own physician when they go to an emergency department, credentialing and hiring practices affect the quality of patient care. As Dr. Jones emphasizes, our patients should be our first priority, and we must better recognize family physicians as competent providers of emergency care.

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Office Procedural Training

To the Editor: The study by Jones et al[1] was helpful in reaffirming some of my own previously published observations on barriers to helpful office procedures such as skin biopsy.[2]

Many of these studies started with an initial observation that hospital-based rotations in surgery and gynecology unintentionally kept residents from developing minor surgery skills in the office. Downstream from the residency, family physicians in private practice repeated the inefficient behaviors they learned in their training programs. Despite lectures, books, and subspecialty instruction, the comprehensive nature of family practice declined.[3,4]

One barrier to skin cancer prevention by means of biopsy was that residents lacked time to perform a biopsy in the midst of their routinely scheduled office visits. To perform unscheduled office surgeries was an administrative nightmare for residents. Furthermore, physicians were not being trained to bring these patients back later. The net result was that patients did not receive needed skin biopsies, flexible sigmoidoscopies, cervical biopsies, and diagnostic sonograms. Even some subspecialty-based procedures, such as colonoscopy and esophagogastroduodenoscopy, were unintentionally "lost to follow-up." Residents were conditioned to avoid these procedures unless they could be easily referred out. There were negative effects on the educational budget and the uninsured patient.[5]

The study[2] noted that more than 90 percent of residents were not able to locate the simple supplies necessary for a skin biopsy even when given 15 minutes to do so. Even though a simple skin biopsy does not require a trained surgical assistant, residents were overly dependent on nurses who had other responsibilities.

The office curriculum did not teach practice management skills through a rigorous and mandatory hands-on orientation to minor surgery. Although faculty thought they had been providing an effective orientation, follow-up testing documented that residents were unfamiliar with their own office practice. Because the family practice model unit lacked a structured curriculum or any accountability in this area, the program produced family physicians who could not perform many office procedures and procedural helplessness developed.

In Memphis we developed mandatory procedural rotations (ambulatory surgery and ambulatory gynecology), subsequently integrating protected time for residents to perform procedures in the office. Under faculty supervision, residents are scheduled to practice