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

in the office providing continuity for their own patients (40 percent time) and providing minor surgery services (60 percent time) for the entire group. Minor surgeries can be scheduled within 1 to 2 days, and urgent care patients can be worked in immediately. A continuity procedural session is provided to third-year residents so they can provide procedural services for their own patients.

I therefore applaud the emphasis on an improved dermatology curriculum, but also encourage readers to consider other curriculum reforms and a continuing evolution whereby teaching is transferred from hospital-based environments into the model unit with accountable family practice faculty who systematically teach minor surgery skills in the office. A loose-leaf textbook that describes the curriculum in detail is available for readers who have an interest in this area.[6]

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