linearity and dose-rate independence with respect to risk."

Robert M. Foster, MD
Roxboro, NC

References

1. Barish RJ. In-flight radiation: counseling patients about risk. J Am Board Fam Pract 1999;12:195–9.
2. Nuclear Issues 1999;21(5). Available from Ruvigny Mansions, Embankment, Putney, London SW15 1LE.
3. Principles and applications of collective dose in radiation protection. NCRP report: no. 121. Bethesda, Md: National Council on Radiation Protection and Measurements, 1995.

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

To the Editor: I thank Dr. Foster for his thoughtful comments on my article, but he is incorrect in claiming that the linear no-threshold hypothesis (LNTH) of radiation dose versus effect is now discredited. At present there is a debate in the radiation protection community about the applicability of the LNTH. Compelling arguments exist on both sides, and the issue has not been settled.

Some professional organizations, including the American Nuclear Society (ANS), have taken positions on the subject, but none has the authority to discredit the hypothesis. The ANS position statement, with all of its supporting documentation, is readily accessible.[1] They recommend that independent experts conduct a review of available data and perform new studies with the goal of obtaining a better model. Many in the radiation protection community feel that any position statement rejecting the LNTH should not be published unless it is accompanied by a specific alternative hypothesis, advocated as a replacement. The ANS has not done so.

Similarly, Dr. Foster's quote from a National Council on Radiation Protection and Measurements (NCRP) document is taken out of context.[2] That line, in fact, appears in a section that reaffirmed use of the LNTH model as an underlying principle of radiation protection by the Council. Recently, the NCRP convened a panel of experts to examine the issue of the LNTH. The draft report of NCRP Scientific Committee 1–6 "Evaluation of the Linear Nonthreshold Dose Response Model" is available for viewing and comment.[3] It is NCRP policy that draft documents cannot be quoted, so at the time of writing of this letter I can only suggest that interested readers look at the draft themselves and decide whether the LNTH is now discredited.

The issue of dose modeling and the LNTH has also prompted a request by the Environmental Protection Agency (EPA) to the National Research Council/National Academy of Sciences to form a new committee with the purpose of updating the BEIR V report on the biological effects of low-dose radiation.[4] The new committee, which will produce BEIR VII (BEIR VI dealt with radon), has been the subject of intense political activism on the part of interest groups who believe that proposed members might bring a preexisting bias based on previous associations with pronuclear or antinuclear causes. These issues of membership are presently delaying progress in the committee's activities.

In summary, the use of the LNTH is still endorsed by all of the regulators of radiation exposure in the United States including the EPA, NRC, OSHA, and the FAA. At present there are several professional societies that have taken sides in the ongoing debate about the validity of this model, but none has advocated a specific alternative hypothesis as a replacement. A forthcoming NCRP report will reflect the council's position. The BEIR VII committee will also evaluate the validity of the LNTH versus other dose-effect models. In my article, I was careful to state on page 196, ". . . the risk of very low dose radiation remains unproved and might in fact be nonexistent. . . . " I believe that I was quite clear in stating that I used the LNTH because it is the model currently advocated by national and international organizations that influence regulatory policy.

At the end of the paper I discussed the possibility of an early warning system for major solar particle events. A pregnant patient could briefly postpone her trip until conditions returned to normal, usually within a day or less. Such a system has now been put into place using a toll-free number that can be contacted just before boarding.[5]

Robert J. Barish, PhD
In-Flight Radiation Protection Services,
New York

References

1. American Nuclear Society. health effects of low-level radiation. Position statement, April 1999. ANS Document PPS-41. Available at www.ans.org. Accessed 23 April 1999.
2. Principles and applications of collective dose in radiation protection. NCRP report: no. 121. Bethesda, Md: National Council on Radiation Protection and Measurements, 1995.
3. National Council on Radiation Protection and Measurements. Evaluation of the linear nonthreshold dose-response model. Draft Scientific Committee 1–6 report. Available at www.ncrp.com.
4. Upton AC, Stoto MA. Health effects of exposure to low levels of ionizing radiation. BEIR V. Committee on the Biological Effects of Ionizing Radiations, Board on Radiation Effects Research, Commission on Life Sciences, National Research Council. Washington DC, National Academy Press, 1990.
5. In-Flight Radiation Protection Services, Inc. 1–877-SUN-FLARE, or 1–877-786–3527.

Inpatient Care of Children

To the Editor: I read with some interest the article in the March-April 1999 issue of the *JABFP* by Drs. Bertolino and Gessner[1] dealing with pediatric admissions by family physicians and pediatricians in a semirural environment.

My comments and questions relate to the implication and comments made in the article as well as to the proposed conclusions. Although the article did a nice job of reviewing hospitalized patients, it did not do a com-

parative study of outpatient visits during that same period. Such a comparative study would have been more representative of the actual number of pediatric-age interactions between the family physicians and the pediatricians. It would also would have given a more accurate reflection of the percentage of patients being admitted from each practice, as well as the percentage of pediatric-age patients being cared for in each of those subpopulations.

To presume that the percentage of hospitalized patients directly represents the outpatient care being provided is a step that needs substantiation. In addition, it is not sufficient to use only the inpatient data for discussing what training needs to be provided in a family practice residency. A comparison even between this study and the Medical College of Virginia studies in the 1970s or other outpatient studies might have added further credence to their discussion and conclusions.

I would hope that we would not try to use only inpatient data to mold our curriculum for our residents.

Ross R. Black, II, MD
Mill Pond Family Physicians
Cuyahoga Falls, Ohio

Reference

1. Bertolino JG, Gessner TP. Pediatric admissions by family physicians and pediatricians in a semirural environment: implications for residency training. J Am Board Fam Pract 1999;12:128–32.

The above letter was referred to the authors of the article in question, who offer the following reply.

To the Editor: I have reviewed the insightful commentary by Dr. Black. It is clearly a mistake to generalize the results of this study to recommend training for the outpatient setting. We do not presume or state in the article that the data on hospitalized patients should be used in this manner. The data were collected on inpatients, and the implications for training were clearly directed toward inpatient training of family practice residents. The data are, in fact, strong, as they are based on more than 1500 hospitalized children cared for by 31 family physicians.

I agree with Dr. Black regarding his hesitation to use this information as the only source for curricular construction, especially since we did not recommend doing so in the article.

Finally, Dr. Black proposes a very good study comparing the total care experience between pediatricians and family physicians. As the purpose of our study was to examine only differences in pediatric inpatient care and how these might be used to structure inpatient training, I do not view his comment as a weakness that detracts from the importance of the study.

John G. Bertolino, MD, MSPH.
Latrobe Area Hospital
Latrobe, Pa.

Professional Identity and Names

To the Editor: I read with rapt interest Dr. Halvorsen's cogent argument for defining our specialty as that of family medicine, and for describing ourselves as family physicians.[1] I found that his suggestions regarding the naming of names resonated powerfully with my own thoughts on the matter. Since my brief medical career began, I have preferred to be called a family medicine resident or a family physician. Dr. Halvorsen articulates well the distinct advantages of those titles. I can indeed reassure him that his musings are not merely those of a physician adjusting to middle age, but reflect concerns, shared by many of my colleagues, about what shape our specialty will take in the next century.

The initialism PCP, objectionable as it might be, has become so entrenched in the realm of medical jargon that it is unlikely to be removed. Rather than seeking to define ourselves as primary physicians, then, we might better spend our efforts in rescuing the meaning of PCP as that of primary care physician (not the languid and detestable phrase primary care provider). Unlike Dr. Halvorsen, I am perfectly happy that primary should modify care, not the physician. Such an arrangement still connotes our special relationship to the patient and seems to sum up the nobler ambitions of our profession by placing emphasis on the care we give, not the persons we are.

As with PCP, so the term *generalist* appears to have linguistic squatter's rights. The suggested alternatives of comprehensivist or extensivist seem awkward to me, but primarily for phonetic and enunciation reasons, not because of cognitive objections. I do not mind so much being labeled a generalist, particularly when I remember that before liberal education became devalued in favor of technical training, the ability to synthesize disparate data into a meaningful whole was considered to be the height of wisdom.

I have previously argued that language has more than a simply nominative function. It also conveys a descriptive, even normative, function. Words tell us not only how things are, they tell us how they should be.[2] Perhaps if we, as family physicians, will give careful thought to how we describe ourselves and to how we choose to fulfill those roles, we will find ourselves better able to meet the needs of our patients and to lead gratifying lives, professionally speaking.

W. Clay Jackson, MD, DipTheol
University of Tennessee Family Medicine Residency
Memphis

References

1. Halvorsen JG. Who am I, professionally speaking? J Am Board Fam. Pract. 1999;12:173–7.
2. Jackson WC. A piece of my mind. In a word. JAMA 1998; 280:493–4.