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.