Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints may prevent this in some cases. The problem is compounded in the case of a bimonthly journal where continuity of comment and redress is difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

One Family of Generalists

To the Editor: As a reader of the *Journal* since its inception, I value the effort put forth by this high-quality publication. It is in this light that I believe a response is needed to Dr. Benson's reply[1] to Dr. Greenberg in the Correspondence Section of the October-December 1990 issue regarding the comparison between family medicine and internal medicine.

Dr. Benson has received a number of replies to his essay and should be assured that he is not alone in his misunderstanding of family medicine. I have no disagreement with him about the importance of primary care. As President of the American Board of Internal Medicine, he takes a courageous stance in advocating primary care. It may be of value, however, to recognize that there are significant philosophical differences between the specialties of family medicine and internal medicine.

The specialty of family medicine has remained committed to its goal of training physicians who are able to provide continuous, comprehensive care to their patients regardless of age, sex, or type of problem. This cohesive approach to patient care is taught to the residents by family physicians. The graduates of family practice residencies almost never subspecialize, whereas internal medicine traditionally has been a breeding ground for subspecialists. Now, internal medicine is developing an interest in primary care and recognizes the current trend of subspecialization as a problem. The specialty wishes to increase the number of general internists and is adding various office rotations to its curriculum. This is a good start, but it does not result in similarly trained physicians. The philosophy and skills taught in these specialties are very different. Family medicine is more than hospital training with the addition of a few outpatient rotations.

While it might be true that family practice residents spend a great deal of time on internal medicine rotations, it is misleading to claim that they receive more training from internal medicine than from any other specialty. In fact, little of their education is from general internists, who typically are not identified as role models for young family physicians. More training is received from subspecialists during these rotations and from subspecialists who serve as consultants. Family physicians provide the most vital aspect of the resident's education, and this process continues in the ambulatory setting during rotations.

To assume that family physicians are not "trained for or interested in the care of the very sick newborn" contradicts the fundamental philosophy of family practice. Pediatric care, including sick newborns, is undeniably an integral aspect of family practice. Also, the practice of obstetrics, which is not addressed by Dr. Benson, is at the very heart of family practice; the delivery of the newborn marks the beginning of the family life cycle. Family practice residents are trained in obstetrics, and their pediatric education includes newborn intensive care rotations providing skills essential for continuity of care, especially in rural areas.

In closing, I would encourage Dr. Benson to continue his exploration of family medicine and its unique philosophy of primary care. Family medicine may not have all the answers, but it may well have ideas beneficial to the training of general internists.

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References

1. Benson JA Jr. One family of generalists [reply]. J Am Board Fam Pract 1990; 3:312.

Blood Cholesterol Lowering

To the Editor: In a recent *JABFP* guest editorial, Dr. Froom[1] advanced three arguments against the use of medications to lower elderly patients' elevated cholesterol levels. Two of his three arguments articulate sound reasons for caution in considering medical treatment for such patients. Many clinicians consider the lack of controlled trials documenting benefit of medical treatment in this population to be sufficient grounds for withholding lipid-altering medications from most, if not all, elderly patients. The only controlled trial that showed preventive benefit from lowering cholesterol in an elderly population was the Los Angeles Domiciliary Trial.[2] This dietary intervention study ran for 8.5 years with 846 men in a Veterans Administration Hospital. At the beginning of the study, most of the men were in their 60s; mean age was 65.6 years.

The potential for adverse drug effects also can be a dissuading factor, despite the fact that physicians treat other chronic health problems in the elderly with long-term medications having far more frequent and serious side effects than the currently used lipid medications. The high cost of lipid-altering prescription medications would seem to be a more serious problem for the majority of patients.

Froom's first argument, however, is not valid. He asserted that the relation between total blood cholesterol