In 1983 Komaroff, et al.[1] reported that 20.5 percent of the 763 adults who presented to their clinic with a sore throat were infected with *Chlamydia trachomatis*, 10.6 percent with *Mycoplasma pneumoniae*, and 9.1 percent with group A streptococcus. Since then, *Mycoplasma* and *Chlamydia* have been implicated as the etiologic agents of pharyngitis in other publications.[2,3] These organisms are not inconsequential because they both are capable of producing pneumonia.[4] Some authors have even incriminated *Chlamydia pneumoniae* as the etiologic agent in endocarditis[5] and as a contributing agent in chronic coronary heart disease.[6]

We can no longer take the position that only sore throats caused by β-hemolytic streptococcus require antibiotic therapy.

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The Best Ideal in Family Practice

To the Editor: While working as a locum tenens in a northern Minnesota town, I read Dr. Stephen's comments[1] and was struck by his observations about personal medicine being the care of a person by a person and his suggestion that when this simple but profound idea is acted out, something remarkable happens. "Both physician and patient cease to be ordinary to each other."

I was immediately reminded of an encounter of that very day. As the "fill in" doctor, I was asked to see a 63-year-old woman who "needed a refill of her Tagamet™." In response to a friendly, "How have things been going?" I learned the following:

1. Her "ulcer symptoms" had returned the past month.
2. One month ago her brother died of leukemia just 6 months after diagnosis.
3. Next week is the fifth anniversary of her husband's death, and she misses him very much.
4. The following week is the 20th anniversary of the violent death of a 20-year-old son.
5. She works at the local hospital around illness and suffering but feels uncomfortable sharing *her* suffering because "health care workers are not supposed to be sick."

The 20 minutes it took to write that Tagamet™ prescription helped us both that day. My temerity at being a "substitute doctor" was dissipated by her need for someone who would accept the responsibility for "looking after" her. For that brief time we "ceased to be ordinary to each other"—just as Dr. Stephens points out.

The opportunity to emphasize this aspect of family medicine and "model" it for medical students is rare. I saw it done with great finesse by Dr. John Stone—a cardiologist from Atlanta—when he read his poetry derived from clinical experience to first- and second-year students at the Mayo Medical School. I would particularly recommend his poem, "To a Fourteen-Year Old Girl in Labor and Delivery" in his book *The Smell of Matches*.[2] Medical students still need exposure to personal medicine, but it is difficult to teach.

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2. Stone J. The smell of matches. New Brunswick, NJ: Rutgers University Press, 1972.

Books Received

Books received by The *Journal of the American Board of Family Practice* are acknowledged in this column. Those that appear to be of particular interest to our readers will be reviewed as space permits.

Child and Adolescent Psychiatry: A comprehensive textbook. By Melvin Lewis (editor). 1282 pp. Baltimore, MD, Williams & Wilkins, 1991. ISBN 0-683-04954-2. $120.

Emergency Cardiac Maneuvers: A rescuer's handbook. Second edition. By Carol E. Bartecchi. 178 pp. Durant, OK, Essential Medical Information Systems, 1991. ISBN 0-929240-15-4. $12.95 (paper).

Ethical Dilemmas in Pediatrics: A case study approach. By Edwin N. Forman and Rosalind Ekman Ladd. 142 pp. New York, Springer-Verlag, 1991. ISBN 0-387-97454-7. $42.

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