resuscitation could be continued. The visiting nurse presented the discharge orders from the hospital indicating the DNR order signed by a physician, but this document was not deemed valid by the EMS crew. Frantically the resident was called to try to convince them to stop, but the EMS crew would not talk to him because they said they could not recognize a verbal order from this physician.

The patient's body was transported to a different hospital from that initially intended because of her "critical status," and the attempt at resuscitation was continued in that emergency department. The family followed and were prevented by hospital security from seeing the patient. Resuscitation efforts were stopped only when the resident was able to reach the emergency department physician by telephone, explain the situation, and ask for resuscitative efforts to be stopped.

Some states including Maryland have guidelines to try to ensure that situations such as the one described here do not occur. The policies of individual states in this regard are outlined in a paper by Sachs, et al.[2] following a survey of state EMS offices. Emergency services are also becoming increasingly aware of the problem.[3] The new Patient Self-Determination Act, which has recently been put into effect, even though it pertains only to institutionalized patients, should also increase awareness of this important issue.

I would be surprised if others among your readers have not encountered similar difficulties, and I would encourage dialogue with local EMS offices to try to ensure resolution of the problem.

Patrick P. Coll, M.B., B.Ch.
David Anderson, M.D.
Saint Francis Hospital and Medical Center
Hartford, CT

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Diagnosis of Multiple Myeloma

To the Editor: The recent *Journal* article by Keenan, et al.[1] highlights several pitfalls in the diagnostic use of bone scans. Another important weakness of the bone scan is its inability to detect multiple myeloma. Reliance on the bone scan to exclude boney involvement by myeloma can lead to the disastrous complication of spinal cord compression, which can occur in 15 percent of patients with myeloma and often happens early in the course of the disease.[2]

Bone pain is the most common symptom in multiple myeloma,[3] and the patient's family physician might use a bone scan as part of the evaluation. The technetium 99 used in many bone scans is taken up by the osteoblasts but not the osteoclasts. Most destructive lesions of bone are associated with osteoblastic attempts at repair, but the bone lesions in myeloma are lytic and rarely associated with new bone formation.

Unfortunately, plain radiographs also are not 100 percent sensitive for myeloma. In perhaps one-quarter of myeloma patients, circumscribed defects can be absent, and in some patients the plain films can be essentially normal.[4] Magnetic resonance imaging (MRI) might provide greater detail on myelomatous abnormality in the vertebral column than conventional radiographs.[2]

The common occurrence of low back pain in primary care precludes the casual use of an expensive and cumbersome procedure such as spinal MRI, but for optimal patient care, the family physician should continue to consider such uncommon illnesses as vertebral osteomyelitis and multiple myeloma in back pain patients.

Floyd L. McIntyre, M.D.
South Dennis, MA

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Nursing Home Patients

To the Editor: Dr. Richard Waltman[1] of Tacoma, Washington, provided readers with a poignant editorial in the January-February issue of *JABFP*. He upbraided family physicians — especially young ones — for declining to see patients in nursing homes.

Dr. Waltman compared the exercise of this freedom with possibly declining to see patients of certain ethnic or racial origins, suggesting that such a decision should "cost the physician his or her medical license."

Obviously there is no comparison here. To have privileges in a nursing home, a physician must comply with rules of attendance, record-keeping, making rounds, and other specific regulations. In fact, the nursing home or a regulatory body can prohibit a physician from attending patients in a nursing home for failure to adhere to strictly imposed regulations.

It seems reasonable for any physician to decline to enter this regulatory morass. In his editorial, Dr. Waltman points out the reasoning for this: "Reimbursement is poor, demands are substantial, and the

hassle factor is high." I for one do not refuse to see nursing home patients, especially those for whom I have cared for in the past. I simply choose not to see them *in the nursing home*, for to do so would add to my bureaucratic burden. I will see them in the office, at the hospital, or even at home; I suspect that many of those family physicians castigated by Dr. Waltman practice the same way.

G.E. Harmon, M.D.
Waccamaw Medical Center
Pawley's Island, SC

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Success Strategies

To the Editor: While I applaud Taylor et al.'s article[1] as a primer for family medicine department heads, I am concerned about the implicit messages it sends to the rest of us: institutional acceptance has replaced institutional change as the desired ideal of family medicine in academia. The article suggests that success in family medicine is measured solely by the traditional criteria of medical schools.

In 1973 Ransom and Vandervoort warned us that family practice and family medicine were moving to accept "the values and biases of an overly specialist-dominated, outmoded system rather than the realities of the primary health care needs of this nation and the challenge of doing things differently."[2 p 1100] The times have certainly changed, but reading Taylor et al., I believe that Ransom and Vandervoort's statement rings true 20 years later. Vast numbers of people still lack access to medical care,[3] and medical costs skyrocket[4] at the same time students choose to enter high-technology specialties.[5] Medical schools, according to Relman in a previous edition of this journal, continue to produce physicians who, "however technically competent they may be, simply don't feel comfortable . . . , or are not interested, or are afraid of relating to their patients as human beings."[6 p 50S]

Clinician-educators in family medicine can and should pursue novel and atypical solutions to these problems, and they should be applauded for these efforts. They should not assume that family medicine has fulfilled its role as a change agent in medical education. They should strive to make family medicine's designation as the academic counterculture a reality rather than a casual reference.

The challenge is difficult for those now training students and residents: to balance integration *and* innovation in filling the many scholarly niches of family medicine in the 1990s and beyond.

William B. Ventres, M.D.
The University of Arizona
College of Medicine, Tucson

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

To the Editor: I thank Dr. Ventres for his interest in the article "Success Strategies for Departments of Family Medicine." I am concerned, however, that Dr. Ventres has inferred a conclusion not intended by the authors, that: "the article suggests that success in family medicine is measured solely by the traditional criteria of medical schools."

I concur with Dr. Ventres: family medicine has an important role in the medical school that includes introducing family practice values and concepts into a highly specialized, often medically fragmented, environment. A medical school department of family medicine, however, cannot effect change in the curriculum or in patient care based upon claims of moral superiority or even public support. Instead, the family medicine department can fulfill its role as a change agent only after its faculty members gain respect in the academic medical center as outstanding clinicians, innovative educators, and productive researchers.

Robert B. Taylor, M.D.
Oregon Health Sciences University
Portland