ceptor needs to delineate when the job as a teacher ends and when the role as a physician begins. As a teacher, having the student provide endless amounts of information without ever making a commitment to a diagnosis leads to lack of learning. Once we have performed our jobs successfully as teachers, we can then put on the physician hat and walk into the room to gather more information directly from the patient, to perform any necessary physical examination, and to provide the patient with our diagnosis and treatment plan.

In teaching the concept of "probing for supporting evidence," we have found another metaphor, the mind map, useful to our preceptors. We describe that the expert's mind map includes clear differential diagnoses for presenting problems and connections of each diagnosis to appropriate evaluation and treatment. The expert's mind map can include looser associations of clinical information with basic science information. In contrast, the student's mind map often includes extensive information about the basic sciences but sparse lists of differential diagnoses, treatments, or evaluation strategies and loose links between these elements. The job of the teacher in "getting a commitment" is to find out where the student is on his or her mind map, and the job during "probing for supporting evidence" is to explore the student's thinking and knowledge around this point on his or her mind map. In using "probing for supporting evidence" in our own teaching with students and residents, we have found that we often do not recognize that a student has not really made a commitment until we begin to probe for supporting evidence. Regarding "teaching general rules," we find that it is important to teach both to what the student or resident is thinking and to what is actually most important in taking care of the patients. For example, in evaluating a patient for sleeplessness, the resident could focus on the choice of an appropriate sleeping medication but ignore the possibility that the sleeplessness is a symptom of depression. In this case it would be helpful to teach the resident additional information about the choice of sleeping medications, as well as teaching him or her to include the diagnosis of depression in the differential diagnosis for sleeplessness.

We appreciate the fact that Drs. Neher, Meyer, and Stevens and Ms. Gordon have described these microskills in the literature. Our experiences in teaching this model and in using the model in our own interactions with students and residents also have been very positive.

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Obstetrics in Rural Family Practice

To the Editor: Greer, et al.[1] and Nesbitt, et al.[2] address important issues in the specialty of family practice about the delivery of health care in rural areas of the United States. In his editorial, Dr. Wall[3] correctly suggests that the multitude of stressors on our health care system in general is magnified in rural obstetrics. I identify with these issues, having practiced in rural Colorado for 17 years. My practice included obstetrics both in group practice and then in solo practice. It was not easy. I quit obstetrics when my insurance premium was to take a 1-year jump of about $10,000 per year. Although this differential for family practice with obstetrics persists to this day, Dr. Wall is correct that liability cost is not the only obstacle here.

The following could be valid reasons why physicians who had promised to take up obstetrics again do not do so:

1. There is significant change in skill and a loss of comfort with that skill when one stops practicing it.
2. If one quits obstetrics, it would be logical to stop reading the literature in that field (there are so many other topics in medicine with rapid technical advances). It would be likely also that one's choice of continuing medical education courses would not be in obstetrics.
3. The anxiety associated with the liability and risks of doing obstetric procedures often outweighs the fees earned. Once the physician becomes free of such feelings, he or she might wonder, "How did I ever do (tolerate) it? Was it worth the money?"
4. Dropping the cost of coverage does not reduce this associated anxiety. Nor does it make us trust the medical legal system more.

The validity of listing liability and liability costs of doing obstetrics as important reasons to stop doing obstetrics is not negated by physicians not returning to obstetric practice if malpractice premiums drop again. Liability and liability costs are important, but there are many other considerations that come to mind after the liability issue is resolved. Dr. Wall discusses some of these; they are real and not easily addressed. We physicians need to be more kind to ourselves and our colleagues. Are we now feeling less good about ourselves, just as society seems to rank us lower? Is this not inappropriate?

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Autonomic Response to Beeper

To the Editor: As a family physician for 25 years I, of course, carried a conventional "beeper" for most of that time. I was in a very busy clinical practice, receiving many telephone calls and being paged frequently. It subsequently came to pass that in response to the beeper beeping, I would develop an anxiety syndrome, complete with tachycardia, diaphoresis, and just an uncomfortable feeling.

I was relieved, therefore, when the new technology was introduced that allowed one to be "vibrated." I fastened the new beeper more or less on the right side and was delighted to have no interruptions by the piercing shrill beep that had made me so uncomfortable. It soon happened, however, that I would be awakened in the middle of the night with a vibratory sensation in the area where my beeper was ordinarily carried. But I was not wearing a beeper. In short, I was having a tactile hallucination in the area of the beeper, which, of course, I found somewhat alarming and unacceptable.

I now carry a wrist beeper that alerts me with one gentle, almost inaudible "ding," which I find much more acceptable and does not seem to elicit the autonomic response that the previous old-fashioned beeper did. I am also happy to report that my tactile hallucinations have resolved. I would be interested to know whether any of your other colleagues have had similar experiences with paging devices.

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