physician-patient e-mail curriculum and increase its usefulness to others. We plan to repeat our survey of knowledge and behavior following full implementation of a physician-patient e-mail curriculum in our institution.

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To the Editor:

Advances in the genomic sciences are catalyzing the emergence of screening for genomic predisposition to breast cancer in primary care. Many practicing primary care physicians lack confidence in their capacity to assess the clinical relevance of their patients’ family history.1 More recent medical trainees who receive education in genomic risk assessment might enter their practice more prepared to address family history and genomic risk. However, little is available that describes current residents’ confidence or educational needs related to genomic risk assessment. Our family medicine program established a curriculum to address family history assessment and patient counseling in 2004. The curriculum includes three components. The first is a half-day workshop for all residents that occurs early in the academic year and is focused on assessing and counseling with a woman about her heritable breast cancer risk and two 3-hour clinical sessions observing cancer genetic counseling. We evaluated resident confidence with aspects of genomic risk assessment and counseling after 2 years of this educational initiative.

Methods: A self-administered questionnaire was given to family medicine residents attending one regularly scheduled resident-only meeting during the winter of 2006. The questionnaire consisted of five questions with a common stem, “I feel confident in my ability to...,” and a common 5-item response option (strongly disagree to strongly agree).

Results: All 23 residents attending the meeting responded (60% of the total residents). Four out of five residents were confident in their ability to assess family history. Fewer residents reported confidence in their ability to engage shared decision making about whether or not to pursue genetic counseling for high-risk women (41%) and in their ability to reassure low-risk women (50%). Confidence in all dimensions was higher for PGY-3 versus PGY-1 residents.

Conclusions: With a family history assessment and patient counseling curriculum, family medicine residents in our program appear more confident assessing familial risk than using such information for counseling and shared decision making. Future curricula should target these needs.

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Comment

“I Could Never Just Take Blood Pressures All Day Long Like You Do in Family Medicine”

To the Editor:

I was caught off guard when one of my surgical colleagues made the above statement to the first-year medical school class we were addressing about career plans. I was surprised that some of my colleagues still have such a poor understanding of what family physicians actually do. I now use the statement as a springboard with student groups into a discussion about what it is I actually do.

To begin with, of course, the problem of hypertension in the United States is neither trivial nor particularly easy to treat. There are an estimated 58 to 65 million hypertensives in the adult population, with a 29%–31% incidence in the 18 year and older age group.1,2 Of those with the disease, the data from NHANES show that only 34% have their blood pressure under adequate control.3 The health burden of this disease in terms of premature car-
diovascular disease, intracerebral hemorrhage, renal disease, and early death is staggering. Given all of the primary and secondary causes of hypertension and the myriad different treatment options depending on comorbidities, ethnic differences, financial resources, and the patient’s desires, treatment of the disease is immensely complicated. Hypertension is an extremely important disease that deserves the careful attention of highly trained individuals who enjoy serious intellectual challenges.

I would argue that if all that I did was treat hypertension then I would be doing a major service to improving the health of many individuals, but of course those of us in family medicine do a great deal more. I describe to the students the challenges of caring for patients with multiple complex problems. Which problems need immediate attention and which can be safely dealt with at the next visit? Each patient presents me with a whole array of medical, social, and psychological challenges that are just as important to the well-being of the patient as the difficult medical and surgical problems that my colleagues in other specialties treat. I also discuss with the students the immense satisfaction I get from being part of my patients’ lives over the years.

It is important that when we discuss career choices with students we be proactive in explaining both the immense intellectual challenges of the problems we face in family medicine and the great satisfaction we gain by helping patients improve their health. This message needs to be constantly presented to the students to counteract the negative misperceptions that our colleagues may have about what we actually do. It is essential that we accurately define the importance of what we do and not allow others to define us incorrectly. We continuously confront serious and intellectually challenging diseases that demand from us all of the skills and expertise we have gained through the years. Family medicine is not a specialty for those who don’t seek to be challenged.

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References