Letters to the Editor

The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Membership in Hospital Departments of Family Practice

To the Editor:

The Department of Family Practice at the Swedish Hospital Medical Center in Seattle should be commended for taking steps to assure that their Department shall not become a wastebasket for physicians with less than adequate training who do not qualify for membership in any other department (*Scardapane JN, McCougall WT: Membership in family practice departments: An urban hospital model. J Fam Pract 13:455, 1981).* We recently faced the same problem here at Richland Memorial Hospital and promulgated similar guidelines. In addition to eligibility for our board qualified and certified physicians, established physicians in the community were "grandfathered" as to whether or not they had at least one year of approved internship and three years of active practice in general or family medicine.

Since this is a tax supported hospital, other physicians applying for membership in the department who do not meet these qualifications are provided access on a two-year probationary basis, admitting patients under the supervision of the chief of service. We feel that there will not be enough applications from the physicians in this category to consitute a burden, and thus far this has been proven true.

The status of departments of family medicine in other hospitals may be enhanced by the adoption of similar measures.

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Bacterial Endocarditis

To the Editor:

The recent article on bacterial endocarditis by Haddy et al ("Bacterial endocarditis in the community hospital." *J Fam Pract 13:807, 1981*) mentioned that 36 percent of their sample in the retrospective study had underlying valvular heart disease; however, no breakdowns made of the specific valvular involvement. Historically, the mitral valve is most commonly involved in bacterial endocarditis, followed

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by the aortic valve, tricuspid valve, and pulmonic valves, respectively.[1]

Echocardiography has also proven to be a most useful tool in evaluating patients with bacterial endocarditis. Wann et al have shown that echocardiography is extremely useful in differentiating the patient with severe bacterial endocarditis who may profit from early valvular replacement.[2] Horowitz and Smith have also demonstrated vegetations echocardiographically on the prolapsing mitral valve,[3] a syndrome now known to be quite common and certainly to become increasingly responsible for bacterial endocarditis in the future. It would be of interest to know what percentage of patients in this study may have had echocardiograms as part of their diagnostic evaluation.

Finally, the authors encourage "appropriate prophylaxis for those at risk." Although the American Heart Association Committee Report published in *Circulation* in 1977 outlined the specific guidlines for bacterial endocarditis prophylaxis,[4] one must remember that the guidelines are empiric extrapolations from animal data, since no human clinical studies have been available to date.

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References

1. Hurst JW (ed): The Heart. New York, McGraw-Hill, 1978
2. Wann LS, Dillon JC, Weyman AE, Feigenbaum H: Echocardiography in bacterial endocarditis. N Engl J Med 295: 135, 1976
3. Horowitz MD, Smith LG: Vegetative bacterial endocarditis on the prolapsing mitral valve. Arch Intern Med 137:788, 1977
4. Kaplan EL, Anthony BF, Bisno A, et al: Prevention of bacterial endocarditis. AHA Committee Report. Circulation 56(1): 139A, 1977

The preceding letter was referred to Drs. Haddy and Gordon, who respond as follows:

We would like to respond to the comments of Dr. Belardi regarding our recent paper on bacterial endocarditis. We do not have good data on the valves involved, since this was a retrospective study based on clinical diagnoses. Because the study covered 15 years, and the technique has only been available for a few years in our community, echocardiography was carried out in only a few patients. We agree that it is an excellent tool and should be routinely used in suspected endocarditis. With regard to antimicrobial prophylaxis, it would seem prudent for the practitioner to follow the recommendations of the American Heart Association until this nationally respected organization tells us it is of no value. Although we have only animal studies on which to base our approach, there is general agreement that it is logical to use antimicrobials at times of particular risk to kill bacteria which enter the blood stream before they can cause endocarditis.[1]

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Reference

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Career Orientations in Primary Care

To the Editor:

In a previous study, Plovnick[1] found that senior medical students choosing family medicine careers had different value orientations toward their careers than those choosing internal medicine. The family medicine types expressed more concern for patient care (eg, helping people) and less concern for professional status (eg, intellectual work) than the straight medicine choosers. A follow-up study was conducted on these same students after three years of residency to measure the impact of residency training on their value orientations.

The follow-up data indicated that the value differences between students choosing internal medicine and family medicine as medical school seniors did not change during residency training. The 13 students choosing family medicine as medical school seniors remained more oriented to patient care, although the gap narrowed somewhat, while the 20 internal medicine choosers were more oriented toward professional status.

However, more than one half of the students included in this study indicated a change in specialty choice during their three years of residency training. Some of those who chose family medicine as medical school seniors switched into internal medicine, and some students choosing internal medicine switched into family medicine as residents.

To assess differences in values between practicing physicians, the value orientations of the third year residents were compared based on their current career choices. The results indicated that while third year residents choosing family medicine were again more concerned about patient care and less concerned about professional status than those choosing internal medicine, the differences between the two groups had decreased below the levels of statistical significance. Those students switching out of family medicine were more oriented to patient care and less oriented to professional status than those switching in.

Contrary to previous studies reporting accentuation of differences between the specialties during the residency years,[2] the specialty groups in this study became more similar during their residency. Although drawn from a small sample, these results may call into question some previous assumptions made about the characteristics of physicians entering the primary care fields. The results may also raise some questions about family medicine residency training regarding the defection of students with appropriate primary care values and the attraction of students with less appropriate orientations.

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1. Plovnick MS: Medical student values, socialization, and primary care career choices. J Fam Pract 11:323, 1980

2. Reinhardt A, Gray R: A social psychological study of attitude change in physicians. J Med Educ 47:112, 1972