LETTERS TO THE EDITOR

To the Editor:—Kyriacou et al.¹ discussed that the best way to improve emergency department follow-up is actually to give the patient a specific appointment. With that strategy, 59% were followed up in the clinic. They do not mention the down side of that strategy which is that 41% of the time, the office physician has a “no show.” Given the costs and pressures to produce in an office practice, a no show rate that is 5 times greater than the normal office follow-up no show rate is not a happy prospect.

It would be interesting to determine the problem for which follow-ups were or were not completed. That is, patients with musculo-skeletal problems that improved would be less likely to show up, but, on the other hand, the dutiful patient with the same resolved problem might show up for an appointment for which there is no medical necessity, and therefore waste everyone's time.

We think that an appointment should be given when follow-up is critical for the care of the patient (i.e., uncontrolled HT, DM, CHF). For the majority of situations where the reasonable expectation is that the patient will improve, the patient should only be given a number to call if they do not improve as expected.—**Gilbert Lowenthal, MD, MBA**, *General Internal Medicine, Cleveland Clinic Foundation, Cleveland, OH, USA*

REFERENCE

1. **Kyriacou DN, Handel D, Stein AC, Nelson RR.** Factors affecting outpatient follow-up compliance of emergency department patients. *J Gen Intern Med.* 2005;20:938.

Author's Response

To the Editors:—Dr. Lowenthal's comments illustrate an important dilemma for emergency physicians. That is, when is it appropriate to recommend that patients treated in the emergency department (ED) follow-up with their personal physician? The many reasons why follow-up recommendations are critical are presented in the introduction of our brief report.¹

Unnecessary follow-up recommendations are frequently made for 2 main reasons. First, emergency physicians do not typically know ED patients and their medical problems as well as the patients' personal physicians. Despite this, ED physicians frequently must make preliminary diagnoses and initiate new treatment plans that can have many significant consequences. Second, because of selection processes ED patients are at much greater risk for serious outcomes compared with private clinic patients. For both these reasons, emergency physicians often tend to err on the side of safety and recommend their patients follow-up with their personal physicians. The reverse also frequently occurs. Personal physicians often send nonemergent patients to the ED for evaluation when their schedules are full and they cannot accommodate the patient in a timely manner. Again, they are erring on the side of patient safety.

I agree with Dr. Lowenthal that the best solution would be for emergency physicians to identify the more potentially seri-

ous ED patients who truly need follow-up, such as patients with poorly controlled hypertension or diabetes. However, this would significantly extend many patients' ED evaluation and add to their length of stay and costs. Contacting these patients' physicians to coordinate care and ensure follow-up would also help, but is not practical in busy EDs for many reasons. Consequently, it is more pragmatic to give ED patients some responsibility for their own follow-up.—**Demetrios N. Kyriacou, MD, PhD**, *Department of Emergency Medicine, Northwestern University Feinberg School of Medicine, Chicago, IL, USA.*

REFERENCE

1. **Kyriacou DN, Handel D, Stein AC, Nelson RR.** Factors affecting outpatient follow-up compliance of emergency department patients. *J Gen Intern Med.* 2005;20:938–42.

In Response to “Medical Students' Views on Peer Assessment of Professionalism”

To the Editor:—Arnold et al.¹ conducted several focus groups of medical students to help determine optimal peer assessment methods that will be acceptable to students. We are concerned, however, that “peer assessment” as it was presented to these student groups² described a mechanism to report classmates' behavior, whether the behavior is concerning (the main focus of students in the study), or exemplary. We would advocate clearly distinguishing peer assessment for feedback purposes from reporting peers' behaviors to others. Although both functions of assessment of professionalism—punitive and formative—are important, they can come into conflict if the distinction is not obvious. As the authors' analysis suggests, students may have greater comfort with systematic peer assessment of all students' professionalism behaviors in a safe environment. In our experience this sort of formative peer assessment can promote healthy reflection, positively affect the “culture” of the medical education environment, reinforce students' strengths, and guide future student learning and behavior (in addition to pointing out concerns).^{3,4}

We have related concerns about the final sentence: “If effective peer assessment can be established, it may offer further insight into students' professional lapses that, when identified by faculty, have been linked to later risk of censure by state licensing boards.” Presumably here the authors are referring to a system that allows prompt reporting about concerning behavior. While periodic systematic peer feedback about professionalism can be extremely important in a formative sense, it is poorly suited for purposes of identifying major lapses in integrity or ethics because it is too far removed from the occurrence. Student comments reported by the authors provide insight into elements that may facilitate reporting of such important lapses. In any case this should be