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Response to Gangat

To the Editor:—We greatly appreciate the interest from our colleagues at the Mayo Clinic in the PRIME curriculum, and the correspondent has brought up several important points. Our inclusion criteria for PRIME does include dedication to ambulatory medicine but it is not the only important basis on which we make our choice. Our residency program at UCSF already has 2 dedicated primary care programs, and PRIME includes a mix of future generalists and subspecialists. The residents entering generalist and subspecialty careers have had similar research productivity and clinical performance scores.

We have avoided comparing PRIME Resident production with the rest of the categorical residency as our residents are chosen, in part, based on their interest in clinical outcomes research. Many of our categorical and primary care track residents also successfully complete outcomes research projects, but this is not as major a focus of their training.

We agree that the publication of interesting case reports is an important scholarly project, especially for trainees, for all the reasons mentioned above in the letter. We included 2 case reports in the bibliography. Case reports can be difficult to publish, as many journals will not accept them. We therefore applaud the recent addition to JGIM of a section on case reports.

We have been lucky in that we have not had to restructure our residency program to provide this training. At UCSF, both second and third year residents spend 6 months in the outpatient setting each year. We have folded the didactics and research time into these months so they are not pulled out of inpatient services to participate. —**Jeffery Kohlwes, MD, MPH, Rebecca Shunk, MD, Jonathan Garber, MD, Michael Shlipak, MD, MPH, VAMC Box 111 4150, Clement St., San Francisco, CA, USA.**

Letter to the Editor regarding Strauss et al.

To the Editor:—I laud Strauss et al.¹ for identifying driving distance as a system barrier to diabetes control. Such studies provide a renewed interest in alternatives to face-to-face visits. It is important to emphasize the potential value of telephone contacts and electronic linkages, as suggested by the authors. There is evidence that clinical outcomes can be enhanced for diabetes,² hypertension,³ and depression⁴ and unscheduled visits can be decreased⁵ through telephone care

contacts. In addition, a recent survey of diabetics indicated that over one-third of those queried were internet users.⁶ I do note, however, that only 1,576/4,209 (37%) of the potential subjects of Strauss's study could be reached by phone. Was the low number of those contacted the result of the lack of a telephone, follow-up attempts to call prospective research subjects, medical record administrative information, or some other reason? Having conducted a VA telephone care clinic from 2001 to 2003 solely to manage diabetes, hypertension, and hyperlipidemia,⁷ I rarely encountered a situation when a patient could not be reached by telephone despite the fact many were of lower financial socioeconomic status and resided in rural areas. I also wonder if those contacted in this study were queried about access to the internet.—**David A. Nardone, MD, (Retired) Clinical Director Primary Care, Staff Physician VHA Medical Center, Professor Emeritus, Oregon Health & Sciences University, Portland, OR.**

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Response to Nardone

To the Editor:—We thank Dr. Nardone for his comments and we agree that alternatives to traditional face to face visits offer potentially valuable means of providing health care.

The low response rate is largely an artifact of our method of contacting potential subjects. If a potential subject did not answer the phone, we chose another subject from the pool of potential subjects. We did not use the aggressive and persistent techniques that would be required in a clinical setting.

Sincerely,—**Kaitlin Strauss, Charles MacLean, MDCM, Austin Troy, PhD, Benjamin Littenberg, MD, College of Medicine, College of Nursing and Health Sciences, and Rubenstein School of Natural Resources, University of Vermont, 371 Pearl St., Burlington, VT, USA.**