The Recent "Estrogen Episode"

TO THE EDITOR: If any of us ever doubted the power of the news media—TV, magazines, newspapers—these doubts were certainly dispelled during the recent "estrogen episode." All physicians, but especially gynecologists, could not help but be impressed, and distressed, by the panic these news releases inspired in our menopausal patient.

And surely many of us felt a creeping sense of guilt. Had we, in our efforts to allay the distressing symptoms of the climacteric, the hot flashes, the night sweats, the dry vagina, betrayed our patients and subjected them to horribly increased hazards of cancer?

Our telephones were kept busy and our office visits grew longer as we tried to explain to our patients, and to persuade them and ourselves that some of this information was taken out of context, and that the final answer was not yet available. But even so, the doubts lingered.

It was, therefore, with great relief that we read Doctor Gordon's discussion on "Postmenopausal Osteoporosis" (Medical Staff Conference, University of California, San Francisco. West J Med 125:137-142, Aug 1976). It was, of course, good to have the positive reenforcement of our belief that "small prophylactic doses of estrogen prevent this bone loss." But even more reassuring to physicians and patients deeply concerned about the apparent increase in endometrial cancer were these two statements by Doctor Gordon:

"There is no evidence of increased mortality from endometrial carcinoma" but that "These data [increased use of exogenous estrogens in women with endometrial cancer] undoubtedly reflect increased detection."

He goes on to suggest that "estrogen-induced . . . bleeding will predictably increase the detection of early endometrial carcinoma and should thereby reduce mortality, just as the Papanicolaou smear did for cervical cancer."

This is good news that probably won't be snapped up by the news media. But a weight has been lifted from the practicing physician's shoulders. And would it not be wonderful if a similar modality could be found that would cause other cancers to bleed, or to speak out somehow, so as to enable us to achieve early diagnosis and cure?

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In Support of Physician's Assistants

TO THE EDITOR: I am responding to the letter by Dr. Eugene Felmar in the June issue [Felmar E: Physician extenders opposed (Letter to Editor). West J Med 124:509, Jun 1976]. Especially in this bicentennial year, I would not contest Dr. Felmar's right to state his beliefs in print, even though they are based on misconceptions about physician's assistants (PA). However, I would like to add my views, which perhaps are better grounded in fact.

To begin with, the term "barefoot physician" —which Dr. Felmar equates with PA—is a name made popular in this country as a result of the publicity surrounding Richard Nixon's visits to China. Recently, that term, as well as PA, has been applied to foreign medical graduates (particularly those of Vietnamese origin who came to America during our airlift operations) who are waiting to take their examinations in this country.

The physician's assistant concept, on the other hand, is a very old one. It started in Western Europe with the idea of providing medical care in rural areas, to the poor and underprivileged, and in Europe's colonies; for example, those in Africa, India and Hong Kong.

In the United States, statistics showed a population increase in the late 1960's in contrast to the constant, fixed number of medical school graduates each year. The Vietnam conflict at the same time was producing large numbers of returning veterans, many of whom were well-trained medical corpsmen who had had to provide care in combat without a physician present.

Several leaders in the medical profession felt that these corpsmen represented a manpower resource that might help resolve the national health insurance stalemate. Dr. Eugene Stead was the first to found a PA program (at Duke University School of Medicine). Since then the number of PA programs continues to grow (Yale, Bowman Gray, Texas, Nebraska, Baylor, Stanford, UCLA and others). It may be interesting to note that the national average education for PA's is somewhere between two and eight years of college, before entry into a PA program.[1-3] Future PA's, once accepted in a program, spend countless hours in classrooms studying such subjects as anatomy, physiology, biochemistry, microbiology, physical examination, clinical diagnosis, cardiology and hematology before clinical rotations. The next year is much like an internship, full of miniresi-

dencies in each specialty of the hospital; for example, internal medicine, pediatrics, surgery, ophthalmology, ENT, orthopedics, psychiatry, Ob/Gyn. Our professors during this two-year period are all MD's.

The concept as a whole has remained constant, as graduating PA's go out to give a helping hand to their physician employers primarily in small suburbs and rural communities. They are under physician supervision, and only undertake those tasks they are qualified to perform.

PA's must take a three-portion examination given by the National Commission for Certification of Physician's Assistants (the American Medical Association and the National Board of Medical Examiners are just two of the members of this commission). This is to become certified (PA-C). In order to be recertified, PA's must maintain their continuing medical education—100 hours every two years, 40 hours of which must be category I (American Medical Association, American Academy of Family Practice, American Academy of Physician's Assistants [AAPA]). Most PA's join local, state and national (AAPA) organizations much like those to which their physician employers belong. PA's also subscribe to medical journals and read new textbooks because they have a firm belief that the medical care they are involved in providing should be the best possible.

Many medical authorities have stated that we still face shortages in primary care. This is quite obvious today in the military. I work at the second largest Air Force hospital, yet we only have one full-time emergency room physician and one full-time general practitioner. With 300 patients seen each day, it would be very difficult for them to manage without the help of three PA's and one nurse practitioner. If they tried, they would have to practice the "second rate medicine" that Dr. Felmar wishes to avoid.

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