the rheumatology rotation at our institution. It incorporates many of the suggestions in the editorial by Stross: a multidisciplinary approach, clinical rounds, formal rheumatology lectures, interaction with personnel from related subspecialties, and allied health workshops on selected topics. The arrangement of this schedule is flexible, and the various components can be adjusted according to the resources of the institution and needs of the trainees. Additionally, by changing the blocks, emphasis can be easily shifted to inpatient or outpatient training.

Based on our experience of rheumatology training for nonrheumatologists, we would like to propose that residents in family medicine who have successfully completed such training be eligible for rheumatology fellowship. This would heighten interest in clinical rheumatology among practicing family physicians, the primary health care providers for the majority of patients with rheumatic disorders, and would generate a pool of well-trained and interested family practice residents to pursue careers in rheumatology. Family practice residents are already eligible for fellowships in various subspecialties such as gerontology, preventive medicine, and sports medicine.

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1. Stross JK: Rheumatologists as an endangered species: a proposal for change (editorial). Arthritis Rheum 35:609–610, 1992
2. Agarwal AK, Britz PB, Kwoh CK, Samuels AJ, Starz TW, Eisenbeis CH Jr: Rheumatology training for non-rheumatologists (abstract). Arthritis Rheum 35 (suppl 5):R14, 1992
3. Schwartz G, Merenstein J, Agarwal A, D'Amico F, Foley E: Rheumatology curriculum during residency: does it make a difference? (abstract). Arthritis Rheum 34 (suppl 9):S81, 1991
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Reply

To the Editor:

I concur with Dr. Harrington that community rheumatologists can play an important role in attracting trainees into the field of rheumatology, but the initial problem is one of exposure. A recent survey of medical school graduates, carried out by the Association of American Medical Colleges, documented that more than 80% of the graduates selecting careers in internal medicine made that decision during the last 2 years of medical school. The opportunities for interaction with community rheumatologists are limited during that critical period, and the role of clinical rheumatologists in academic centers becomes increasingly important. It would be interesting to assess where rheumatology trainees had their house officer training and when they made the decision to enter rheumatology, as additional data points for program planning purposes.

The distribution of funds from the NIH will always be a source of concern, since basic scientists, clinical researchers, and politicians all have their own agendas. The fact that the NIH has taken the lead in developing the "Academic Award" concept and the basic researchers who populate most NIH councils have approved these awards speaks to their perceived value.

The educational program developed by Dr. Agarwal and colleagues is an excellent example of how community rheumatologists can incorporate clinical rheumatology into family medicine training programs and produce significant improvements in knowledge, skills, and attitudes. Agarwal et al now propose that family medicine trainees be eligible for rheumatology fellowships. That career path has been followed by a few trainees to date, and while subspecialty certification is not possible, this has not been problematic. This approach could expand the potential pool of fellows, but raises several issues: Is the 3 years of internal medicine house officer training prior to fellowship necessary? Should subspecialty certification requirements be changed? Is certification necessary and valuable? These issues have been addressed in the field of gerontology, where family medicine trainees can participate in fellowship programs, and they should be addressed by the ACR.

The ACR's efforts to address manpower issues are ongoing, and it is important that a variety of alternatives be considered, irrespective of their source. The ACR must work in conjunction with the NIH, the Agency for Health Care Policy and Research, and other federal agencies that may be in a position to change resource allocation and facilitate funding of educational initiatives. There will obviously be a variety of approaches to address the manpower issues, and the ACR Manpower and Training Committee is an appropriate forum for these discussions.

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Of names and abbreviations

To the Editor:

The use of abbreviations has become a time-honored custom in the writing and practice of medicine. Certainly, who would not recognize, at least in rheumatology circles, that "RA" and "SLE" refer to "rheumatoid arthritis" and "systemic lupus erythematosus," respectively. The widespread use of abbreviations in medicine indeed seems practical in our communications with colleagues. One could argue, however, that for some people, the English designation "SLE" may mean something entirely different, such as St. Louis encephalitis. In fact, not too long ago, a Houston newspaper printed in large letters on its front page that Texas was again facing another epidemic of SLE.

I have recently noticed two articles published in *Arthritis and Rheumatism* in which the use of abbreviations could similarly confuse the reader–rheumatologist. The article by Wigley et al (1) uses the abbreviation "ACA" to refer to the presence of anticentromere antibody. Yet, for most rheumatologists, "ACA" would bring to mind "anticardiolipin antibody." In another article, Khraishi et al (2) use the