knowledge of, and interest in, certification at the time of admission to the program is minimal in my experience. On the other hand, the great majority of practice-eligible physicians attempt certification for reasons of personal challenge and professional satisfaction. Dr. Green's assumptions, which are misleading and inaccurate, discredit the motives of the CFPC's 3500 certificants.

I am confident that the Canadian Medical Association's task force on family practice will gather evidence to refute Dr. Green's arguments. By so doing the certification issue will be placed in proper perspective.

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To the editor: At the risk of stoking the fire of controversy over certification in family medicine I would like to comment on some points raised by Dr. R.L. Perkin in his editorial (*Can Med Assoc J* 1982; 126: 757–758).

As Perkin somewhat defensively admits, the College of Family Physicians of Canada (CFPC) has yet to conduct a well designed prospective study to show that residency training in family medicine is better preparation for general practice than a rotating internship. This can hardly be considered a "phoney issue" since it justifies the very existence and usefulness of the whole program.

In addition, residency represents the expenditure of time and energy as well as decreased income for the trainee. This extra year may mean less expense to the public because the trainee is paid a lower salary, but during that year society is minus one independent practising physician, who treats considerably fewer patients per day; yet someone still bills the system for the patients seen.

Perkin states that "it is just as difficult to practise good family medicine as it is to practise a specialty". This may well be true, but the patient populations differ considerably, as does the length of training required. Patients seen by a specialist are preselected. In addition, patients treated by a general practitioner tend to have more psychosocial illnesses and fewer serious physical illnesses than those seen by specialists. It follows that specialists deal with "sicker" patients (or those who represent more of a diagnostic dilemma).

Many of my peers agree that residency is good for those who practise in an urban centre with support facilities (specialists and tertiary care hospitals) but that it is not appropriate for a small town or a rural setting, where physicians may be called on to perform a greater number of technical procedures. Indeed, most see a better preparation for this setting as a rotating internship followed by a year of additional training in obstetrics, anesthesia or emergency medicine. For many, certification represents merely the security of being able to acquire hospital privileges on entering practice.

I fully agree with the proposal that the second year of the family medicine program be open to those completing a rotating internship. Why the CFPC first needs assurance that the complete 2-year program be available to all trainees in that stream is difficult to comprehend, but I suspect this decision is based mainly on political and financial factors rather than on true concern for the "quality" of their graduates.

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A case of familial lingua bifida?

To the editor: A 2-year-old boy was brought to the craniofacial clinic by his parents for an examination, as his condition had been of some surprise to his pediatrician. He seemed in excellent health, his vital signs were normal and his disposition was cheerful, but when he opened his mouth to laugh he was seen to have a forked tongue. The separation was in the midline and extended as far as the attachment of the frenum. The fungiform papillae were denser along the midlines of the forked portions of the tongue. All other structures were normal for his age. Although not yet able to speak the child made some attempts to "talk" out of both sides of his mouth at the same time, and his habit of thrusting the apices of the two forks against his incoming anterior teeth was causing them to tilt forward and separate, a tendency that could cause orthodontic problems.

The family history of lingua bifida was confined to the child's father, a state legislator, and a forbear, who as a young man, attached himself to the Lewis and Clark expedition, selling beads and mirrors to the Indians. The boy's paternal great-grandfather did not have lingua bifida but was a trial lawyer who pleaded the case for the defence or the prosecution according to the fee offered. The father's tongue had been surgically reunited, with loss of taste and sensation along the suture line, when coincidentally he had almost lost his seat in the legislature. He had refused permission to have his case published.

Because of his own experience with "running off at the mouth" and his proclivity to "doublespeak" the father wished to have the same operation performed on his son. The boy was admitted to our hospital for surgery. The mucosa was removed from along the mesial edge of the furcation, the exposed muscular surfaces were apposed and the two halves were sutured together. Histologic examination of the superficial layers showed no abnormality. Healing was by first intention and recovery was uneventful.

Lingua bifida has appeared twice in the popular press but never in the scientific literature. Both cases were reported from hospitals in the District of Columbia. The patients, both men, were not related except by profession — one was a senator and the other a congressman of considerable seniority. In their cases the division of the tongue had been less deep; the cleft had formed during their second term in office and had deepened with the number of orations. These two cases were probably sporadic but our patient appeared to have inherited the condition from his father. Perhaps we have a case of Lamarckian inheritance rather than autosomal dominant inheritance with sex-limited expression?

The disadvantages of lingua bifida are, first, orthodontic if the subject has acquired the habit of tongue-thrusting and, second and of greater concern, sociologic and esthetic. Our patient's father admitted that he was not a great elocutionist, but since his own operation he had found that his acceptance by his peers and in his neighbourhood had greatly improved. Surgery at any age is recommended to alleviate this abnormality.

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Involuntary admission to hospital and treatment in Ontario [correction]

An error appeared in the article by Drs. M. Menuck and S.K. Littmann in the May 15 issue of the Journal (1982; 126: 1168–1171). In the third sentence of the second paragraph under Discussion the quotation should have read (with the correction in italics): "It is *sad* that the review board procedure exists to assist a young man in such a self-destructive course." We apologize for this oversight.—Ed.