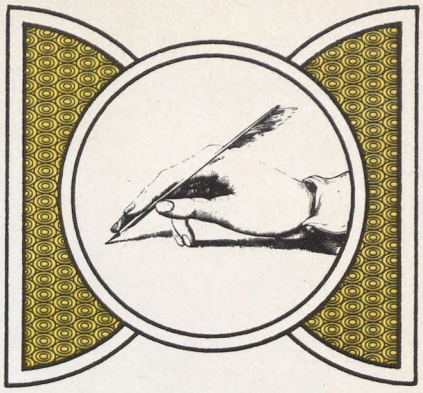
Letters to the Editor



The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

On Obstetrics in Family Practice

To the Editor:

The recent article by Mehl et al in *The Journal (Mehl LE, Bruce C, Renner J; Importance of obstetrics in a comprehensive family practice. J Fam Pract 3:385-389, 1976)* causes me some concern. It is the thesis of the authors that family practice groups practicing without obstetrics not only do very little obstetrics, but consequently, little pediatrics, gynecology, and family therapy.

I agree with the introduction regarding the need for the family physician to be occupied with the entire family without regard to issues of age or sex. The problems arise with the methodology and numbers used to support the authors' conclusions.

It is stated that all four practices studied were composed of members who entered practice with plans to deliver comprehensive, continuous family health care. The authors mention that members of each of the four practices included individuals with one or two years of post-medical school training, but we are not told about the details of that training with respect to whether the physicians were primarily educated through a rotating internship background or within a recognized and certified family practice program. This is the basic flaw in the paper since, on the basis of the results, we are supposed to think carefully about the future of obstetrics in family practice training programs. This we cannot really do, since we have no basis for comparison.

The results of the study show that out of four family practices, the two which did obstetrics also did a reasonable amount of pediatrics, gynecology, and family therapy. The two that did little or no obstetrics were also inactive in the other areas.

The authors then attempted to relate the actual practice to attitudes of the practitioners including satisfaction with their current style and plans for potential change. This area of their study can be summarized by saying that those who were doing obstetrics and the other related disciplines were happy and planned to continue doing what they were doing, while those practitioners who did not were unhappy, insecure in the other areas, and furthermore, were considering changing fields from family practice into other, more narrow fields, such as emergency medicine, or perhaps going for additional training in one of the traditional specialties. My interpretation of their Table 1 on attitudes relates simply to the observation that

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those who were secure in their full role of family physicians were happy, while those who were not secure were unhappy. Without basic information on training, however, my interpretation is possibly unfounded.

On page 387, the statistical significance between the groups based on the characteristics of their patient distribution is given with p values in almost all cases less than 0.001. In my opinion, this presentation represents a misuse of statistics. The fact is that the number of cases is small and the dependent versus the independent variables are connected in a non-causal way. As mentioned earlier, if the groups are basically non-comparable because their backgrounds differ substantially, the fact that there is a coincidental statistical significance neither adds support to, nor detracts from, the generalizations being made.

Similarly, the elaborate graphic and tabular presentation of the basic facts, which show the described differences in practice and attitude, appear to me to go beyond the solidity of the data, especially since we again are missing some key information upon which interpretation might become reasonable.

The San Francisco Bay area community is over-doctored and heavily oriented towards the traditional specialties. The community standard is to have a pediatrician, or an internist, or an obstetrician/gynecologist. Therefore, the family practitioner who elects to practice family medicine in its fully comprehensive form must be attitudinally and cognitively prepared to compete in that buyer's marketplace. If he is to practice obstetrics, pediatrics, family therapy, etc, he must be extremely well trained and sure in his role, since he is going against the community standard. It is, therefore, unreasonable to expect that the possibly inadequately trained family physicians who composed at least practices 3 and 4, could effectively compete in that environment. Those who made up practices 3 and 4 at the outset, or over time, appeared to degenerate into some variety of generalist for adults, and we do not even know how they were trained for that role.

Finally, the authors suggest that for the concept of comprehensive family medicine to remain viable, obstetrics must remain an important part of family practice. This certainly cannot be denied. They suggest further, presumably on the basis of their data, that residents not planning to include obstetrics in their future practice might best join a primary care, internal medicine program.

This conclusion is perhaps their opinion, but cannot be based on the data that they present for the reasons already described. It is an oversimplified suggestion, perhaps based on the authors' own feelings about what a family practice ought to be. It neglects the possibility that there are multiple possible variations within a family medicine context depending on the environment, and the orientation of the graduate of the program.

For example, it may be just possible that family practitioners in the San Francisco Bay area, and in other similar, urban environments, may have some difficulty in building up a substantial obstetrical practice because of the community standard and ob/gyn physician over-supply (a fact not supported by the figures for practices 1 and 2). The family physician wishing to do more obstetrics and gynecology because he wants to and has been trained to, may find the alternative model of close association with a sympathetic and supportive ob/gyn group to allow excellent family-oriented obstetrical care, delivered in a family medicine context, while still preserving optimal care for his patients both at the human and technical level.

I suggest this only as one possible alternative to dumping those who do not fit within a particular mold to the as-yet-undefined and untested role of the primary care internist.

In summary, I found the article to be interesting and extremely thought-provoking, but disturbing in a journal that has been preeminent in helping to develop a scientific base for the discipline of family medicine.

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