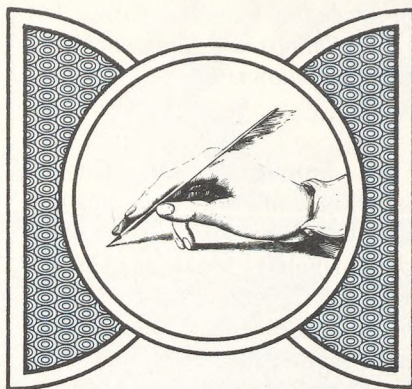


# Letters to the Editor



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.

## Outcome of Obstetric Care in Family Practice

To the Editor:

I was interested to read the paper by Drs. Phillips, Rice, and Layton on the comparison of obstetrical case outcomes between general practitioners, family medicine residents, and private obstetricians (*Audit of Obstetrical Care and Outcome in Family Medicine, Obstetrics, and General Practice. J Fam Pract 6:1209, 1978*). The conclusions of the study, that the care provided by family medicine residents compares favorably with the others, may be modified by some variables that the authors might well consider.

First, there arises the question of the random selection of 50 patients from each group's patient population. How was this randomization undertaken and were these 50 cases representative of all the patients and the work carried out by each group of physicians? This certainly does not represent an equal sampling of the total patient populations, since the sample of family medicine residents' total cases was 63 percent; of private obstetricians' patients, 12 percent; and of the

general practitioners, 57 percent. One cannot therefore conclude that the 50 selected cases from each group reflected the characteristics of that group, nor can one make comparisons of the three groups and extrapolate the conclusions to the general performance of family medicine residents.

Secondly, it would be useful to know whether the supervision of residents at each delivery by family medicine faculty and private general practitioners played a significant role in decision making in the care of their obstetric patients. If this was indeed so, conclusions regarding the performance of the family medicine resident group should include comments regarding not only residents but also faculty members and private general practitioners. Did the latter physicians also form part of one of the other two groups studied, the private general practitioners? If so, this tends to cloud the comparisons undertaken.

Continued on next page



MSD  
MERCK  
SHARP  
DOHME

**ALDOMET**<sup>®</sup>  
(METHYLDOPA | MSD)

TABLETS: 500 mg, 250 mg, and 125 mg

Continued from preceding page

Thirdly, the implied conclusion that the Family Medicine Group undertook fewer interventions and anesthesia, thus ensuring a more "natural" childbirth may well be a valid one, but could also be explained either by a reluctance (for whatever reason) to resort to forceps extractions, or the type of birth preparation to which the women were exposed in the prenatal period. It has been reported that Lamaze training leads to less frequent narcotic therapy, less conduction anesthesia, and a higher rate of spontaneous vaginal deliveries.<sup>1</sup>

Unfortunately, the study of childbirth is filled with a host of interrelated variables, some accurately measurable, others attitudinal and social in nature. Consequently investigations in this field are notoriously difficult to undertake. This present study, which is a good start to establishing the effectiveness of family medicine in providing obstetric care might well be developed into a prospective randomized controlled trial in order to further validate the conclusions reached by Dr. Phillips and his co-workers.

Peter Curtis, MD  
Assistant Professor  
Department of Family Medicine  
University of North Carolina  
Chapel Hill

#### Reference

1. Scott JR, Rose NB: Effect of psychoprophylaxis (Lamaze preparation) on labor and delivery in primiparas. *N Engl J Med* 294:1205, 1976

The preceding letter was forwarded to Drs. Phillips and Layton who respond as follows:

We appreciate Dr. Curtis' thoughtful comments regarding our study, "Obstetrical Care and Outcome in Family Medicine, Obstetrics, and General Practice" (*Phillips WR, Rice GA, Layton RH: J Fam Pract* 6:1209, 1978), and share his interest in further study of the role of family medicine in obstetric care.

To answer Dr. Curtis's first question, our random patient selection process consisted of retrospectively taking the total number of patients in each of the three groups for the year studied and randomly selecting 50 patients from each. We thereby attempted to avoid the introduction of bias in patient selection attributable to time of year, previous duration of resident training, and other factors. Although it is true that the equal 50-patient samples do not represent equal proportions of their respective random and representative samples. Insofar as observed differences meet statistical tests of significance, valid conclusions can be made about the likelihood that the differences observed between the samples represent actual differences between the populations. Of course, extrapolations to populations other than those studied must be made with caution.

The second point regarding supervision of resident deliveries by family medicine faculty and private general practitioners is an in-

Continued on page 250

## NOVAFED® Capsules

pseudoephedrine hydrochloride  
Controlled-Release Decongestant

**DESCRIPTION:** Each capsule contains 120 mg. of pseudoephedrine hydrochloride in specially formulated pellets designed to provide continuous therapeutic effect for 12 hours. About one half of the active ingredient is released soon after administration and the rest slowly over the remaining time period.

**ACTIONS:** Pseudoephedrine is an orally effective nasal decongestant with peripheral effects similar to epinephrine and central effects similar to, but less intense than, amphetamines. It has the potential for excitatory side effects. At the recommended oral dosage, it has little or no pressor effect in normotensive adults. Patients have not been reported to experience the rebound congestion sometimes experienced with frequent, repeated use of topical decongestants.

**INDICATIONS:** Relief of nasal congestion or eustachian tube congestion. May be given concomitantly with analgesics, antihistamines, expectorants and antibiotics.

**CONTRAINDICATIONS:** Patients with severe hypertension, severe coronary artery disease, and patients on MAO inhibitor therapy. Also contraindicated in patients with hypersensitivity or idiosyncrasy to sympathomimetic amines which may be manifested by insomnia, dizziness, weakness, tremor or arrhythmias.

Children under 12: Should not be used by children under 12 years.

Nursing Mothers: Contraindicated because of the higher than usual risk for infants from sympathomimetic amines.

**WARNINGS:** Use judiciously and sparingly in patients with hypertension, diabetes mellitus, ischemic heart disease, increased intraocular pressure, hyperthyroidism or prostatic hypertrophy. See, however, Contraindications. Sympathomimetics may produce central nervous stimulation with convulsions or cardiovascular collapse with accompanying hypotension.

Do not exceed recommended dosage.

**Use in Pregnancy:** Safety in pregnancy has not been established.

**Use in Elderly:** The elderly (60 years and older) are more likely to have adverse reactions to sympathomimetics. Overdosage of sympathomimetics in this age group may cause hallucinations, convulsions, CNS depression, and death. Safe use of a short-acting sympathomimetic should be demonstrated in the individual elderly patient before considering the use of a sustained-action formulation.

**PRECAUTIONS:** Patients with diabetes, hypertension, cardiovascular disease and hyper-reactivity to ephedrine.

**ADVERSE REACTIONS:** Hyper-reactive individuals may display ephedrine-like reactions such as tachycardia, palpitations, headache, dizziness or nausea. Sympathomimetics have been associated with certain untoward reactions including fear, anxiety, tenseness, restlessness, tremor, weakness, pallor, respiratory difficulty, dysuria, insomnia, hallucinations, convulsions, CNS depression, arrhythmias, and cardiovascular collapse with hypotension.

**DRUG INTERACTIONS:** MAO inhibitors and beta adrenergic blockers increase the effects of pseudoephedrine. Sympathomimetics may reduce the antihypertensive effects of methyldopa, mecamylamine, reserpine and veratrum alkaloids.

**DOSAGE AND ADMINISTRATION:** One capsule every 12 hours. Do not give to children under 12 years of age.

**CAUTION:** Federal law prohibits dispensing without prescription.

**HOW SUPPLIED:** Brown and orange colored hard gelatin capsules, monogrammed with the Dow diamond followed by the number 104. Bottle of 100 capsules (NDC 0183-0104-02).



DOW PHARMACEUTICALS  
The Dow Chemical Company  
Indianapolis, IN 46268

**AMOXIL®** (amoxicillin)

For complete prescribing information, consult Official Package Insert.

**Indications:** Amoxil® (amoxicillin) is similar to ampicillin in its bactericidal action against susceptible strains of Gram-negative organisms—*H. influenzae*, *E. coli*, *P. mirabilis* and *N. gonorrhoeae*; and Gram-positive organisms—*Streptococci* (including *Streptococcus faecalis*), *D. pneumoniae* and non-penicillinase-producing staphylococci. Culture and sensitivity studies should be obtained. Indicated surgical procedures should be performed.

**Contraindications:** A history of a previous hypersensitivity reaction to any of the penicillins is a contraindication.

**Warning:** Anaphylaxis may occur, particularly after parenteral administration and especially in patients with an allergic diathesis. Check for a history of allergy to penicillins, cephalosporins or other allergens. If an allergic reaction occurs, discontinue amoxicillin and institute appropriate treatment. Serious anaphylactic reactions require immediate emergency treatment with epinephrine, oxygen, intravenous steroids and airway management.

**Usage in Pregnancy:** Safety for use in pregnancy is not established.

**Precautions:** Mycotic or bacterial superinfections may occur. Cases of gonorrhea with a suspected primary lesion of syphilis should have dark-field examinations before receiving treatment. In all other cases where concomitant syphilis is suspected, monthly serological tests should be performed for a minimum of four months. Assess renal, hepatic and hematopoietic functions intermittently during long-term therapy.

**Adverse reactions:** Untoward reactions include: glossitis, nausea, vomiting and diarrhea, skin rashes, urticaria, exfoliative dermatitis, erythema multiforme and anaphylaxis (usually with parenteral administration). Although anemia, thrombocytopenia, thrombocytopenic purpura, eosinophilia, leukopenia, and agranulocytosis have been noted, they are usually reversible and are believed to be hypersensitivity phenomena. Moderate elevations in SGOT have been noted.

**Usual Dosage:** Adults—250 to 500 mg orally q. 8h (depending on infection site and offending organisms). Children—20-40 mg/kg/day orally q. 8h (depending on infection site and offending organisms). Children over 20 kg should be given adult dose.

Gonorrhea, acute uncomplicated—3 Gms as a single oral dose (see PRECAUTIONS). Serious infections, such as meningitis or septicemia, should be treated with parenteral antibiotics.

**Supplied:**

**Capsules—**  
250 mg in bottles of 100's and 500's, unit-dose cartons of 100.  
500 mg in bottles of 50's and 500's, unit-dose cartons of 100.

**for Oral Suspension—**

125 mg/5 ml and 250 mg/5 ml in 80 ml, 100 ml and 150 ml bottles.

**Pediatric Drops for Oral Suspension—**

50 mg/ml in 15 ml bottles with calibrated dropper.

**Beecham**  
laboratories  
Bristol, Tennessee 37620

Continued from page 246

teresting one which we considered in our study but did not report due to lack of information. Both groups attended resident deliveries and the private general practitioner attendings were indeed a subgroup of the private general practitioner group studied separately. The significance of their role in patient management decision making is difficult to assess, but we feel that in general residents make decisions and manage their obstetrical patients independently with the attending serving as back-up for discussion, teaching, and emergencies. Certainly the common effect these private general practitioners may have had on both the family medicine and the general practice groups may cloud the comparisons made. Such a common effect, however, would serve only to decrease any observed differences between the two groups, representing larger true differences between the populations. Thus, the conclusions based on significant observed differences are valid despite the cross-over effect, although we may have failed to observe more minor differences where they may actually exist between the populations.

Dr. Curtis's third point accurately describes our feeling that the decreased degree of obstetrical intervention in the family medicine group compared to the obstetrics and general practice groups is due primarily to a difference in style and philosophy of practice and patient education.

We agree that our study represents only a starting point in the investigation of the effectiveness of family physicians in obstetric care.

Further studies exploring this important area of family health care are underway within the University of Washington Affiliated Family Practice Residency Network. We expect future studies will both confirm and contradict some of our findings as they document the nature of obstetrical care delivered in other family medicine programs and in other practice settings.

William R. Phillips, MD, MPH  
Richard H. Layton, MD  
Department of Family Medicine  
University of Washington  
School of Medicine  
Providence Family Medical Center  
Seattle, Washington

**Research in Family Practice**

To the Editor:

After reviewing the papers on "Research in Family Practice" (*J Fam Pract* 7:49, 1978), I was taken by both a feeling of excitement for the future and concern about the present. In view of the discussion on attitudes for change, it has been my experience that some of our colleagues in the established medical disciplines are not only inflexible but are easily threatened by the search for better ways to approach or manage clinical problems.

One can only guess why many of our bastions of education foster such provincial attitudes. Hopefully, future research will be able to develop in a risk-free, fluid, open-ended, and self-critical atmosphere which will promote true growth, a big job for one specialty.

Lawrence I. Silverberg, DO  
Diplomate, AAFP  
Columbia, Maryland