OBSTETRIC OUTCOMES IN RURAL PRACTICE

To the Editor:

Kriebel and Pitts have done considerable work in reviewing the obstetric outcomes in their small hospital setting (*Kreibel SH, Pitts JD: Obstetric outcomes in a rural family practice: An eight-year experience. J Fam Pract 1988;27:377-384*). In comparing their findings to those of other centers, they have considered many factors that may reflect obstetric care. Crude perinatal mortality rates (PNMR) do not, however, necessarily tell us that there is high-quality care.[1] In their paper, crude PNMRs are used to compare obstetric outcomes between different centers. Birthweight-specific PNMR, being one of the major determinants of perinatal mortality,[2] would have been a better choice.[3] This not only reflects good obstetric outcome but high-quality obstetric care as well.

This does not mitigate the findings from the Forks, Washington, data, since it is possible to calculate and compare their birthweight-specific PNMR to both the Rosenblatt findings in New Zealand and our findings in rural Ontario.[4] In all three studies, small hospitals have similar PNMR in the 1500- to 2500-g weight category and in the greater than 2500-g birthweight category (Table 1). In addition, roughly 4% of babies weighing less than 2500 g were born in a small hospital setting. Whether this number is acceptable would depend on such local factors as distance to a tertiary center, prenatal care, socioeconomic factors, and inclement weather.

We concur with Drs. Kriebel and Pitts that small hospitals can provide high-quality obstetric care within a regionalized perinatal system.

Geordie Fallis, MD, CCFP
Earl V. Dunn, MD, CCFP, and
John R. Hilditch, MD, MPH, CCFP
Don Mills, Ontario

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1. Rosenblatt RA, Teinken J, Shoemach P: Is obstetrics safe in small hospitals? The evidence from New Zealand's regionalized perinatal system. Lancet 1985;2:429–432
2. Chamberlain G: Background to perinatal health. Lancet 1979;2:1061–1063
3. Bonham GH: The measurement of birth outcome. Can J Public Health 1988;79:385
4. Fallis GB, Dunn EV, Hilditch J: Small hospital obstetrics: Is small beautiful? J Rural Health 1988;4(2):101–117

The preceding letter was referred to Dr. Kriebel, who responds as follows:

In response to the letter by Dr. Fallis and his colleagues, let me say the following: The emphasis they place on birthweight-specific mortality is, of course, important. The comparison table they have constructed for my data and the Rosenblatt et al and Fallis et al studies, however, is probably not a valid comparison table. There are two reasons why the table, although interesting, is probably not valid. The first is that when broken out, our birthweight-specific mortality numbers are probably far too small to be statistically significant. I am not a statistician and cannot verify this fact. It is only a hunch that the standard deviations for these rates under the Forks Community Hospital are probably quite large. The other problem has to do with the age of the data. The Rosenblatt et al data were gathered during a time roughly equivalent to the years for the Forks data; however, the Fallis et al study represents 1985 data, and as Fallis et al clearly demonstrate in their own study in the *Journal of Rural Health*, there are precipitous drops over the last two decades in the perinatal mortality rate. This makes comparisons across the years, especially in the last two decades, not unlike comparisons of prices in economic analyses.

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TABLE 1. COMPARISON OF BIRTHWEIGHT-SPECIFIC PERINATAL MORTALITY RATES AMONG 3 STUDIES

	1500 g			1501–2499 g			2500 g			Crude PNMR		
Study	PND*	Total Births	Rate per 1000	PND	Total Births	Rate per 1000	PND	Total Births	Rate per 1000	PND	Total Births	Rate per 1000
Forks Community Hospital	3	5	600	3	47	63.8	4	970	4.1	10	1052	9.5
Rosenblatt et al (87 hospitals)	63	115	547.8	68	1451	46.9	17.4	54677	3.2	305	56243	5.4
Fallis et al (105 hospitals)	38	213	178.4	16	397	40.3	38	13762	2.8	92	14372	6.4

**PND—perinatal deaths*

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GUIDE TO COMMUNITY RESOURCES

To the Editor:

The family physician focuses upon the patient in the broader context of his family and the larger community outside the hospital walls. It is especially important that the family physician be aware of the various resources that the community offers his patients. Whether large or small, urban or rural, each community affords the physician certain kinds of help in the management of the social and psychological as well as physical problems of his clients.

The *Quick Guide to Some Representative Community Resources* was created as a teaching aid for residents in the Family Medicine Residency Program at the Medical University of South Carolina. The guide serves as a tool that helps the physician "think" community resources and, most important, act on the thought. Only then can the practicing physician, resident, or teacher integrate such resources into patient care and the general curriculum. Problem solving for a particular patient becomes a lesson learned in community resources.

Printed on heavy-weight paper, the *Quick Guide to Some Representative Community Resources* is a pocket-sized (4 by 6½-inch) expandable brochure composed of four two-sided panels. It is designed to fit into the physician's coat pocket, to be incorporated into his personal pocket-reminder system, or to slip under his glass desk top for ready reference.*

Key resources in the community appear under the following general headings: emergency, child-adolescent, family, financial, geriatric, support groups, and rehabilitation. Individual resources are subsequently listed alphabetically by name with telephone number under the appropriate category. Lastly, the departments, clinics, and services of the hospitals with which the family medicine resident is affiliated during his three years of postgradute education are given, together with key listings for other hospitals in the area.

The guide is updated annually so as to coincide with the beginning of the academic year. A popular teaching tool with the family medicine residents, it is made available to medical students serving clerkships in the Family Medicine Center and selectively to medical, nursing, and pharmacy students in various teaching settings across the university campus. Attending physicians and house staff on other services, as well as family physicians in private practice, also request copies, thus making it a resource in itself.

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*Requests for copies of the Quick Guide to Some Representative Community Resources should be addressed to: Mrs. Louise J. Guy, Department of Family Medicine, Medical University of South Carolina, 171 Ashley Ave., Charleston, SC 29424.

HEALTH, HEALING, AND THE MEDICAL MODEL

To the Editor:

I am very happy to see work like that done by Dana King and colleagues *(King DE, Sobal J, DeForge BR: Family practice patients' experience and beliefs in faith healing. J Fam Pract 1988;27:505-508)* being published. It addresses several important issues for family physicians. But before exploring these, I would like to settle some definitions, specifically for the terms *traditional medicine*, *healing*, and *health*.

Traditional medicine in the above-mentioned article is taken to mean modern allopathic medicine. Actually, modern drug therapies and high-technology procedures are of fairly recent historical development, with little tradition behind them, unless one considers drug treatment as just a special case or toned-down version of herbal medicine. More accurately, traditional medicine should refer to folk medicine, herbal remedies, shamanism, faith healing, and so on. I prefer the term *conventional medicine* for modern allopathy, as it is widely practiced by most physicians.

Dr. King also raises the issue of physicians as effective healers. What is an effective healer? Can we know what that is before we know what healing is? What is healing? Do we know anyone who is healed or healthy? A good or operating definition of health needs to encompass more than an absence of physical symptoms. Relieving a person's physical symptoms does not necessarily cure that person, though it may. Health manifests on several simultaneous levels. Many physicians speak of the physical, emotional, mental, and spiritual levels. While no specialists need restrict themselves, physicians by the nature of their specialty are more naturally geared to consider all of these levels. So what is health? An absence of physical complaints? A good sense of humor? Poise and balance? Spiritual attunement? The definition I currently operate from is "an acceptance and allowing of life." This may not be all-encompassing, but it has been very helpful for me.

If this is health, what is healing? An obvious answer is that healing is the process of becoming more accepting and allowing of life, whatever life is. Again, there is more than this to healing; there is the mystery of its unpredictability, its ability to happen under any number of circumstances. But if this is healing, then what does a healer do? Do physicians as people filling the role of healers in our culture really know what they are doing? If they concentrate just on physical symptom relief and do not consider the multidimensionality of people's lives, are they really being the most effective catalyst for change they can be? If they do not try to address other patients on every level of their being, patients will become dissatisfied with their service and look elsewhere for care. Physicians need to validate people's life experiences.

If a person relates to the physician experiences of healing that fall outside of the current medical mode, rather than discounting that person's experience, perhaps the physician should question the breadth and depth

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of the model. As scientists, physicians are obliged to consider all the data and be willing to change their ideas in light of new data. The goal is a model that explains every aspect of human experience, just as for the physicist, the goal is a model that explains all natural phenomena. Family physicians, again, are in a position to observe a wider range of human experience than that seen in the more limited specialties. Family physicians, therefore, need to keep trying to expand and refine the medical model from which they all work.

Family physicians, by staying focused on the goal of being the best healers they can be, will be drawn by their patients into the multidimensionality of healing. They all feel that gentle pull every day, and perhaps they should go with it. Consider alternatives. Take the time to become aware of the benefits and uses of other therapeutic modalities such as massage, nutrition, chiropractic, homeopathy, acupuncture, and others. Patients are seeing these folks anyway, so take the time to meet practitioners of alternative therapies, judge for yourself their sincerity, consider referring patients to the ones you feel comfortable with. Cooperation fosters much more healing than competition.

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Seattle, Washington

RELIGION AND FAMILY MEDICINE

To the Editor:

I enjoyed the excellent November 1988 issue of *The Journal of Family Practice* with its discussion of religion and family medicine.[1,2] Both articles go far in documenting trends in family medicine research.

I was particularly intrigued by the thoughtful editorial of Foglio and Brody.[3] I fear, however, they commit a subtle solipsism in their attempt to make religion a true partner with medicine. We are to believe faith is the mechanism whereby medicine and religion are unified through reason. By defining faith as "taking risks on sufficient evidence" where "acting on faith . . . implies both willingness to risk and possessing the sufficient knowledge upon which prudent persons are willing to risk," one discounts or sufficiently lessens the leap of faith without evidence required for many religious beliefs.

Each patient will inevitably witness deteriorating health and death. By acting on faith through evidence, patients may "lose faith" after contrary evidence appears and, instead of hope, feel despair. In whom or what was faith placed and was the faith linked to outcome or evidence? This "faith" based on evidence (trust?) is certainly prevalent. However, I fear this view of faith encourages further distrust of religion. Indeed, it is this view of faith, relying on evidence, that ultimately lends itself to disproof through rigorous trials and valid claims of quackery.

I submit that religious faith often requires no evidence. This faith is often not dependent upon outcome or further evidence. Those with this faith still have inspirational hope despite diminishing evidence for health and improved quality of life. I respect this faith.

As a clinician, I must work diligently with knowledge and skill to develop a reputation that leads patients to trust medical science; if successes occur, I may inspire hope. Trust is the bond I hope to seal in my physician-patient relationship, as faith is the bond believers have with religion. It is a beautiful experience when medicine can involve physician-patient trust as well as patient faith to advance "healing."

Cannot religion and medicine be true partners by fulfilling patients' needs in their uniquely different ways? Cannot we, as family physicians, utilize both spheres of reason in appropriate ways? My most fulfilling cases in practice have been based on mutual physician-patient trust accompanied by the bonus of patient faith. As physicians, we may lessen the inevitable pain and suffering of our patients by recognizing that through their faith they may become whole, even if not cured.

Paul A. James, MD
Bethel, North Carolina

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2. King DE, Sobal J, DeForge BR: Family practice patients' experiences and beliefs in faith healing. *J Fam Pract* 1988; 27:505–508
3. Foglio JP, Brody H: Religion, faith and family medicine. *J Fam Pract* 1988; 27:473–474

The preceding letter was referred to Drs. Foglio and Brody, who respond as follows:

We appreciate Dr. James' thoughtful comments. Our editorial was not intended to establish an identity between religion and medicine. Rather, we wished to suggest that an apparently unbridgeable gulf between the two is narrower than commonly thought.

Dr. James is correct in suggesting that religious faith requires no evidence, if by "evidence" he means only scientific, empirical data. We wished to expand the concept of "evidence" to cover various sorts of personal knowledge[1] as well as the more usual sorts of medical or scientific knowledge.

John P. Foglio, DMin
Howard Brody, MD, PhD

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1. Polanyi M. Personal Knowledge: Toward a Post-Critical Philosophy. Chicago, University of Chicago Press, 1985