LETTERS TO THE EDITOR

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OBSTETRICS IN FAMILY PRACTICE

To the Editor:

Rarely does an issue of any family practice journal appear without an article examining the place of obstetrics in family practice. The recent *Journal* article by Smith, Green, and Schwenk[1] contributes to this literature and parallels its general thrust, which has been to show that providing obstetric care in family practice can be a rewarding aspect of practice, influences practice demographics in a way that some find desirable, and provides attractive, high-quality, and cost-effective patient care. Although the findings are rarely described as such, this literature also demonstrates that providing obstetric care is a minor and shrinking area of practice by family physicians and is becoming increasingly limited to academic settings—this factor alone accounting for two thirds of the variance between obstetric practitioners and nonpractitioners in the Smith et al study.

The tenor of writing about obstetrics in family practice, indeed the avowed intention of the authors, is to promote this style of practice. It should be a cause of some concern that in this area academic practices are increasingly unlike community practices in our specialty. If this trend continues the "town-gown" and "ivory tower" problems that characterize other clinical specialties will increase in family practice. What might be the long-term effects of academic programs so heartily embracing a style of practice increasingly rejected by its own graduates and current colleagues?

The philosopher John Anderson[2] advises us to ask of social institutions not "what end or purpose do they serve" but rather "of what conflicts are they the scene?" Rhetoric around the issue of obstetrics in family practice may be the scene of conflict between idealists and pragmatists in family practice. With increasing realization of the critical need for personal family physicians,[3] and with medical students, as Casey Stengel would have it, "staying away in droves" from our specialty,[4] this conflict in values could assume a great importance.

Will family practice remain a small and idealistic counterculture, fade away as an historical footnote, or play a predominant role in a rational health care system? The way in which we examine and portray practice options to our students and residents and the ways in which we respond to the realities of practice in many settings will likely play important roles in this determination. Acting on the cherished beliefs of academics while remaining oblivious of the conclusions of our colleagues in practice is a course that involves some peril for the family practice movement.

Surveys on the issue of obstetrics in family medicine generally allow for only negative reasons for not including obstetrics. Malpractice (the lawyers won't let me do it), lifestyle (I'm too lazy) and cost (somehow, I can't seem to make any money at this) are frequently cited. Consider the following, however: Fifteen short years ago, when I began my family practice career, there was one cephalosporin. Hypertensive treatment included diuretics, hydralazine, reserpine, and methyldopa. Propranolol was approved only for angina. Ibuprofen was a new drug—the first of its ilk. Very few expected comprehensive health screening. Insurance was simple. It generally only paid when you were in the hospital. Patients with uncomplicated myocardial infarction spent 3 to 4 weeks in a hospital. Congestive heart failure and new-onset diabetes mellitus were conditions calling for several days in the hospital.

Practice complexity and overhead were orders of less magnitude than they are today. We need to consider how the current greater level of complexity, cost, and demand for outpatient services affects our specialty. Something has to give as the complexity and intensity of outpatient medicine increase. For the majority, obstetrics has been discontinued. Increasingly, hospital practice will follow. How we relate to our colleagues making these difficult decisions and how our specialty adapts to these changes will play important roles in determining our future.

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2. Anderson J: Studies in Empirical Philosophy. Sidney, Angus & Robertson, 1962
3. Mulhausen R, McGee J: Physician need: An alternative projection from a study of large, prepaid group practices. JAMA 1989; 261:1930–1934
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BALINT GROUPS AND DIFFICULT PHYSICIAN-PATIENT RELATIONSHIPS

To the Editor:

The article by Schwenk et al[1] entitled "Physician and Patient Determinants of Difficult Physician-Patient Relationships" addresses a topic worthy of study. Characterizing this relationship in practice will, it is hoped, lead to productive methods of dealing with the situation. I do, however, take issue with their statement that "there is little in the medical literature that would help physicians better understand the interpersonal dynamics of a difficult physician-patient relationship. Similarly, there is little help for educators who wish to teach students

and residents how to deal better with such relationships."

The work of Michael Balint, initially published in 1957, with revision in 1964, speaks directly to those concerns. *The Doctor, His Patient and the Illness*[2] chronicles Balint's experience in seminars with a group of British general practitioners discussing difficult patients. In Balint's words, "our chief aim was a reasonably thorough examination of the ever changing doctor-patient relationship." The problem he set out to investigate was "why does it happen so often that, in spite of earnest efforts on both sides, the relationship between patient and doctor is unsatisfactory and even unhappy?"

Granted that the experiences related in the book and its sequel were anecdotal and that Balint is a psychiatrist (thus his writings might be characterized as being in the psychiatric literature), in fact his methods and conclusions most emphatically do not focus "almost exclusively on the characteristics of patients who have been labeled as difficult."[1] The solutions proposed are not based on the assumption that the patient is the root of the problem, as Schwenk protests, but rather on improving the "drug" doctor, that is, the therapeutic effectiveness of the physician himself or herself.

The Swedish Hospital and University of Washington Family Practice Residency Programs have been using Balint groups as a basis for teaching for a number of years (beginning during my training in 1977). These have offered valuable insight to family physicians in training with respect to dealing with difficult patients, in part by examining the physician's emotional responses to an encounter and using that as a basis for understanding patient and self better, thus ideally reducing frustration in dealing with that patient's particular problems.

One approach to dealing more productively with difficult patients for those of us now in practice might be to develop Balint-type discussion groups among family physicians in a given region. The participation of a psychologist, social worker, or psychiatrist skilled in interviewing, observation, and group dynamics may be paramount to the success of such a group. The logistics of gathering a group of busy practitioners and finding a facilitator with the above skills plus interest in the project may prove difficult in many areas of the country. Even in suburban practice with resources available, it is difficult. Perhaps funding, if needed, could come from state family practice foundations, particularly if the group formed the basis of a research project.

Schwenk et al take previous remedies to task for aiming "at adapting physician behavior to cope with difficult patients." Yet, in fact, is that not what he suggests that the problems appear to require in his enumerated conclusions? I agree that indeed this path toward the solution of the problem would seem to be the best. I believe as well that the tools for teaching and learning those skills are available and have been elucidated in the work of Balint and others. It remains for us to creatively implement these techniques within the context of our practices.

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1. Schwenk TL, Marquez JT, Lefever LD, Cohen M: Physician and patient determinants of difficult physician-patient relationships. J Fam Pract 1989; 28:59–63
2. Balint M: The Doctor, His Patient and the Illness, revised ed. New York, International Universities Press, 1972

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

My co-authors and I appreciate the perceptive comments of Dr. Pomeroy, as well as his creative suggestions. We do, indeed, believe the physician is responsible for helping difficult physician-patient relationships become more productive and satisfying. Our concern, and the motivation for this study, is that most past literature suggests that the physician "owns" the solution, but the patient "owns" the problem. Our study suggests, as Balint has eloquently described, that the physician "owns" both. We agree with Dr. Pomeroy that Balint groups may be a well-described approach to training physicians (at any level) to manage patient relationships better. Unfortunately, Balint groups have been successfully introduced into family practice training only rarely, perhaps due to a lack of trained group facilitators. A more significant barrier to the successful use of Balint groups may be that physicians see these groups as a solution to someone else's problem, namely the patient's. Hopefully, our study and Dr. Pomeroy's suggestions will help to remove this barrier.

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ASSESSMENT OF OBSTETRIC RISK

To the Editor:

I appreciated updating my review of the literature on obstetric risk-assessing with the recent study by Dr. Eric M. Wall et al on "The Relationship Between Assessed Obstetric Risk and Maternal-Perinatal Outcome."[1] The risk-assessment instrument used at the Oregon Health Sciences University appears to have adopted the best of the Hobel and Goodwin-style forms, while retaining the cumbersome length of the Hobel form. The weights of the individual risk items varying from 1 to 5 would at first glance appear to add to the sensitivity and specificity of this instrument.

It would be of interest to see the sensitivity and especially the positive predictive value of this instrument when a combined outcome measure was obtained from all significant independent measures of outcome of interest. The recent study by Kelly et al[2] noted dramatic improvement of the positive predictive value of three risk-scoring instruments when using this combined measure. I agree with Dr. Kelly that this approach would yield more clinically useful information for

family physicians in anticipating any of a group of adverse outcomes.

I also look forward to seeing more in-depth analyses of psychosocial risk factors and their effect on perinatal-maternal outcome. Psychosocial factors have been shown to successfully predict adverse outcomes in an otherwise low-risk population.[3] Much of what is missing in a pure medical model will surely be found in addressing deficits in coping skills, self-esteem, and beliefs about birth, to name a few.

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1. Wall EM, Sinclair AE, Nelson J, Toffler WL: The relationship between assessed obstetric risk and maternal-perinatal outcome. J Fam Pract 1989; 28:35–40
2. Kelly RB, Acheson LS, Zyzanski SJ: Comparison of three prenatal risk scores in a series of low-risk pregnancies. Fam Med 1988; 20:122–127
3. Peterson GH: Birthing Normally: A Personal Growth Approach to Childbirth, ed 2. Berkeley, Calif, Mindbody Press, 1984, pp 201–224

The preceding letter was referred to Dr. Eric Wall and Ann Sinclair, who respond as follows:

The risk-assessment instrument used at the Oregon Health Sciences University and evaluated in our paper[1] was never viewed as a model of an ideal risk-assessment tool. Indeed, our evaluation of the predictive value of this instrument was prompted by our skepticism that it would offer any significant information above and beyond that provided by good clinical judgment.

Dr. Armetta raises two distinct issues. First, the predictive value of such an instrument should logically increase when single outcomes are combined because of increased prevalence. The study of Kelly et al[2] did find that when independent outcome measures were combined, the positive predictive value for each of three risk-scoring instruments increased. There are, however, some difficulties with this approach. When measuring the efficacy of a risk-assessment instrument, one cannot evaluate the predictive value without precisely defining the outcome of interest to be predicted.[3]

Adverse obstetric outcomes include perinatal mortality and morbid conditions ranging from low Apgar scores, preterm births, and low birthweight infants, to cesarean section deliveries. The prevalences of each of these outcomes are quite different. When individual outcome measures are combined, they are all considered to be equivalent and, in this case, to be avoided. However, we know that perinatal mortality is to be avoided at all costs and simply cannot be equated with primary cesarean section as an adverse outcome. On the other hand, risk assessment that predicts a combined adverse outcome measure may indeed be useful in rural areas for transfer of high-risk individuals to more specialized care prior to delivery.

The second issue raised in Dr. Armetta's letter is that of the inclusion or, more frequently, the exclusion, of psychosocial risk factors in determining maternal-perinatal outcomes. Few would doubt the importance of psychosocial factors in pregnancy. We would agree that what is missing in current obstetric practice is the incorporation of these factors in a meaningful, predictive fashion. We see it incumbent upon family medicine researchers to pursue ths important area of research.

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2. Kelly RB, Acheson LS, Zyzanski SJ: Comparison of three prenatal risk scores in a series of low-risk pregnancies. Fam Med 1988; 20:122–127
3. Wall EM: Assessing obstetric risk: A review of obstetric risk-scoring systems. J Fam Pract 1988; 27:153–163

IMPORTANCE OF BOARD CERTIFICATION IN FAMILY PRACTICE

To the Editor:

I agree with Curry's statement that the ease with which any doctor can label himself as a family physician, regardless of training, may reduce confidence in our specialty. (*Curry HB: Family medicine as a career choice. J Fam Pract 1989; 28:231-238).*

I entered my family practice residency in 1975 during the early years of the specialty and was in the first graduating class for my program. I felt that board certification was really meaningful and have since been recertified at the appropriate times.

I joined a group practice where all of the older physicians had taken the original boards, mostly as a matter of pride and principle, even though some of them were planning to practice only a few more years. I am certain that many of my patients do not know whether I am board certified, or even what this represents. I rarely get asked if or where I did my residency. There are plenty of certificates on the wall, but I do not know that anyone bothers to read them. Usually, patients are "just coming to see the doctor," and that is that.

Despite the American Academy of Family Physicians' campaign of "don't you wish you had a doctor that specialized in you," I am not certain how many patients really recognize us as specialists. Even the recent membership campaign of the AAFP appeared to be encouraging all comers and did not seem to draw the line between physicians who were board certified and those who were not.

There is a solo practitioner who is my age down the block from us in town who has neither residency training nor board certification. Yet, he bills himself as a "family physician" in the telephone book and in advertisements on the radio or in the local newspaper. When he applied for privileges at a local hospital several years ago, he was given the standard "family practice privileges" including full obstetrics. The only difference is that

my colleagues and I were able to get a few more surgical-type privileges because of our residency experience.

Our group voted not to ask him to cross-cover on our patients (although we occasionally cover for him) because of the discrepancy in training and the possible liability that might be incurred, especially in obstetrics.

Often at social gatherings, I am asked if I "enjoy being a GP." If my wife is present, she faithfully responds that I am a board-certified family physician.

I, therefore, propose that we confine the title of "family practitioner" to board certified physicians if we want to maintain the dignity and respectability of our specialty. Since older physicians are no longer able to "grandfather in," the future family physicians will all be residency trained. While the surgeon mentioned by Dr. Curry who lost two fingers would be allowed to continue in office practice, let him be called a general practitioner.

If there is no worth to the differentiation between those who are board certified and those who are not, how can we expect our younger physicians in training to be willing to finish residency programs instead of just completing an internship and still earning a reasonable living in some drop-in clinic or an emergency room?

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