Letters to the Editor

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ADOLESCENT PREGNANCY

To the Editor:

Grand Rounds in the January issue of the Journal concerns "The Problem of Teenage Pregnancy."[1] Although I find the overall content to be timely and accurate, there are a few aspects of the problem that deserve additional discussion.

First is the importance of improving access for teenagers to contraceptive services. I agree with Dr McGrew's suggestion "to increase effective contraceptive use," and I agree about the importance of correcting "misinformation about the more effective forms of contraception," primarily oral contraception. Many teenagers, however, lack access to affordable, confidential contraceptive services. The National Panel on Adolescent Pregnancy and Childbearing recognized this: "The availability of contraceptive services to adolescents depends heavily on public support, in particular funding through Title X of the Public Health Services Act, Medicaid, and other federal and state maternal and child health programs. In light of the *demonstrated effectiveness* [emphasis added] of contraceptive use in reducing early unintended pregnancy, continued support of these programs is essential."[2] Title X Family Planning funding has been cut by 60% during the Reagan-Bush administrations, however, mainly because of opposition from conservatives and religious fundamentalists.

Second is the absence in Dr McGrew's discussion in the section "Approaches to the Problem" of a recognition that the condition causing adverse effects on the health status of teenage women (and also on educational achievement, employment status, etc) is teenage *childbearing*, not teenage *pregnancy*. This distinction leads to policy implications: "Reducing teenage *childbearing* [emphasis added] should be our first priority. If necessary, I would sacrifice the goals of reducing adolescent sexual activity and adolescent pregnancy to attain this one."[3] The National Panel also made alternatives to childbearing one of its three major goals: "Although we strongly prefer prevention of pregnancy to avoid parenthood, abortion is an alternative for teenagers for whom prevention fails."

There is considerable public misinformation about abortion. Abortion is at least twenty times safer for the teenage girl than continued pregnancy.[4] Recent research shows overall improvement in teenagers' psychological status, educational attainment, and postponement of additional pregnancies when teenagers having an abortion were compared both with teenagers who continued their pregnancy and with sexually active teenagers who sought pregnancy testing but were not found to be pregnant.[5]

In light of these observations, it would seem that the approach of the medical profession in reducing teenage childbearing should be education and political action.

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References

1. McGrew MC, Shore WB. The problem of teenage pregnancy. J Fam Pract 1991; 32:17–25.
2. Risking the future: adolescent sexuality, pregnancy and childbearing. Washington: National Academy Press, 1987.
3. Trussell J. Teenage pregnancy in the United States. Fam Plann Perspect 1988; 20:262–72.
4. Rosenberg MJ, Rosenthal SM. Reproductive mortality in the United States: recent trends and methodologic considerations. Am J Public Health 1987; 77:833.
5. Zabin LS, Hirsch MB, Emerson MR. When urban adolescents choose abortion: effects on education, psychological status, and subsequent pregnancy. Fam Plann Perspect 1989; 21:248–55.

The preceding letter was referred to Drs McGrew and Shore, who respond as follows:

We appreciate Dr Ferguson's comments and we agree with his concerns.

Perhaps the term *adolescent childbearing* would have been more accurate than *adolescent pregnancy* for the focus of this Grand Rounds. We chose to focus primarily on the outcome, both medical and psychosocial, of a young pregnant woman choosing parenthood, rather than abortion or adoption, and the consequences for both teenage mothers and fathers. The case presentation clearly illustrates a teenager who chose the option of parenting.

In the section entitled "Approaches to the Problem" we decided to briefly discuss some approaches to reducing adolescent pregnancy as the first step to reduce adolescent childbearing and parenting. Indeed, we agree with Dr Ferguson's point that effective contraceptive use by adolescents cannot be improved for these teenagers without good access to contraceptive services. Political activism on the part of health care providers who care for adolescents will be essential to restore support of Title X Family Planning Funding and to prevent further cuts.

Conspicuously, and unfortunately, absent in that same section is mention of abortion as an option to reduce teenage childbearing. Over one third of adolescent pregnancies are terminated in abortion.[1] We strongly support the option of abortion as a solution to unintended and undesired pregnancy. Because of the very factors that Dr Ferguson mentions, access to safe abortion is even more tenuous than access to other contraceptive services. We join Dr Ferguson in hoping that young women will not once again feel that they are forced into terminating their pregnancies via unsafe "back-alley" abor-

tions. Again, provider and community activism will be essential in maintaining these services.

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Reference

1. Teenage pregnancy. The problem that hasn't gone away. New York: Alan Guttmacher, 1989.

HIV EXPERIENCES OF FAMILY PHYSICIANS

To the Editor:

Bredfeldt et al *(Bredfeldt RC, Dardeau FM, Wesley RM, Vaughn-Wrobel BC, Markland L, AIDS: family physicians attitudes and experiences. J Fam Pract 1991; 32(1):71–5)* reported on family physicians' experiences with HIV disease. Although the respondents in that study were representative of the *entire membership* of the American Academy of Family Physicians (AAFP) based on region and community size, it was not clear whether they represented the demographics of the AAFP's *active membership*. This report concluded that 46.6% of physicians treated at least one HIV patient and about 33% of physicians in rural areas "dealt" with HIV.

We have also surveyed family physicians to understand their HIV experiences. We acquired a national random sample of 2660 *active members* of the AAFP with a response rate of 63.7%. We found that 23.2% had not tested any patients for HIV during the previous 12 months; 56.6% had tested 1 to 10 patients; 15.9% had tested 11 to 50; and 4.2 had tested more than 50 patients. In response to the second question, 67.1% had no HIV patients; 30.3% had 1 to 10; 1.9% had 11 to 50; and 0.5% had more than 50 HIV patients.

Of the physicians who said they had tested 1 to 10 patients, 34% were rural physicians and 70% were urban physicians; of those physicians who had tested 11 to 50 patients, 18.4% were rural physicians and 81.6% were urban physicians; and of those physicians who tested more than 50 patients, 19.6% were rural physicians and 80.4% were urban physicians ($P<.001$). We also found that 25% of rural physicians cared for 1 to 10 HIV patients compared with 75.2% of urban physicians; 8.9% of rural physicians cared for 11 to 50 HIV patients compared with 91.1% of urban physicians ($P < .001$).

These data suggest that family physicians provide less care to HIV-infected patients than claimed by Bredfeldt. Bredfeldt correctly asserts that family physicians stand on the "front line" of HIV disease; unfortunately, our data do not support that family physicians are as well prepared for the approaching assault as Bredfeldt may contend.

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

Our survey included only active members of the AAFP as stated in our methods section. The proportion of respondents from each region of the nation and community size closely mirrored the active membership at the time of our survey.

Ryan et al state that 67.1% of respondents to their survey reported having no HIV patients compared with 53% of respondents in our study. Although I wonder how significant this difference really is, I believe several explanations exist for this apparent discrepancy:

1. *Sampling technique and question content.* Obviously, it is difficult to compare the results of two different survey instruments unless the wording of the surveys are identical. The survey by Ryan et al seems to have focused on 1 year's experience of family physicians in testing and caring for HIV disease. Our survey asked respondents if they have cared for any HIV-infected patients during the course of their professional practice. It is not surprising that a survey covering a span of several years would have a higher experience level than one covering a 1-year period. It should also be noted that the differing response rates (72.5% vs 63.7%) indicate at least some differences in sampling technique.

2. *Survey timing.* The experience of family physicians with HIV disease is an extremely fluid one. Unless the surveys were conducted during the same time frame, it is difficult to compare their results.

Given the limitations in comparing these two studies, I believe the results are certainly "in the same ballpark."

One final comment. Our study makes absolutely no contention regarding the preparedness of family physicians in caring for HIV-infected patients. We simply relayed the results of reported experiences with this disease. We did suggest, however, that one reason why almost one fourth of respondents would refuse to care for an AIDS patient may be their belief that they lack adequate knowledge of this disease. Furthermore, we emphasized that physicians must receive the education and training necessary to meet the demands of this epidemic. Rather than contend that family physicians are "prepared for the approaching assault," I would instead contend that the assault has already begun. It is essential that family physicians now meet that assault.

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CLARIFICATION OF PATIENT VOLUME

To the Editor:

We were naturally very interested to read David Schmidt's commentary on our recently published article *(Knishkowy B, Furst A, Fassberg Y, et al. Multiple family member visits to family physicians: terminology, classification, and implications. J Fam Pract 1991; 32:57–64)* that appeared recently in the Journal, and particularly for his assessment that this research "adds another link in a chain of evidence that strongly supports the concept that the family is an appropriate unit of care in family practice." We would like to take this opportunity, however, to clarify the query raised by Dr Schmidt about the seemingly small number of patients seen by the Israeli family physicians who participated in the study compared with their counterparts in the United States.

There are several reasons for the smaller than expected number of recorded encounters. One factor is the number of clinical sessions in the typical Israeli family physician's work week. Although physicians employed by the Israel Labor Federation's Sick Fund work 5½ days per week, 1 full day is dedicated to continuing education. Another half day is often set aside solely for home visits, highlighting one of the qualitative differences between family practice in Israel and in the United States.

A significant proportion of the patients seen by participating physicians were excluded from this study. Residents of kibbutzim (collective communities), not included in the study, constituted approximately one half of the patient population of two of the physicians (subtracting 1½ physician weeks from the study). Also not included were the routine prenatal and well-child visits, which comprised up to 10% of all encounters. In addition, one physician held a position that included only half-time clinical family practice (subtracting 1 physician-week from the study), and three others had teaching and/or administrative responsibilities in addition to their clinical work.

We may therefore recalculate the number of patients who would have been seen per physician per day had all physicians worked 5-day (instead of approximately 4-day) in-office weeks, and had all office-based encounters (including well-child and prenatal visits) been included. Beginning with 899 patient encounters, we estimate that 1236 patients would have been seen. Since the study included 11.5 physician-weeks, this corresponds to about 21 patients per day per physician.

The patient volume per hour (and thus the time available per patient) was thus similar to that in a typical American family practice setting. At the same time, this letter reemphasizes some of the differences between these Israeli practices and US family practice, and hopefully will stimulate further study of multiple family member visits in other settings.

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