Editorials

Prenatal Care – A Serious National Dilemma

Recently, a blue-ribbon committee of obstetricians released a public announcement that, after deliberate study, they concluded that some pregnant women eligible for federal entitlements need not receive as many prenatal care visits as they have in the past. It was believed the costs for the care of pregnant women who are at low risk for complications might be excessive.

Some practicing physicians have found this announcement to be rather startling. While the majority would agree that controlling the costs of federal entitlement programs is probably sound economically, many would question the wisdom of reducing support for appropriate preventive care. This would seem especially problematic in prenatal care. Comparisons with outcomes of pregnancy in other countries clearly suggest that the United States needs to improve the quality and quantity of prenatal and perinatal care.

Concern has been expressed that further reductions of the meager incentives to provide quality prenatal care could result in even higher rates of prenatal morbidity and mortality. However, at the same time, physicians cannot ignore the possibility that they might be "over-doctoring" some patients. There is a persistence of the dilemma in national policy that tries to balance quantity, quality, and cost. If one of these three variables changes in a positive direction, one or both of the other two variables must change in an adverse direction.

Aside from the micro- and macroeconomic issues, the practitioner must ultimately decide what is best for the patient. Are there sufficient data to predict an appropriate frequency and timing of prenatal care visits? Should this question be addressed by a massive multisite primary care study? If such a study were done, would society be any closer to resolution of the dilemma of cost versus quality versus quantity? The number of variables to be considered is significant. Our ability to measure some of the variables is limited, e.g., cultural background, health beliefs, and family influences.

Irrespective of national policy, the physician retains the ultimate responsibility for the provision of prenatal care. Sound scientific principles tempered by a thorough understanding of the patient and family in the context of the community environment must be applied assiduously. Physicians must not be seduced into ignoring the individual needs of the patient or the intrinsic value of the doctor-patient relationship. Prenatal visits should not be reduced to a perfunctory assessment of physiologic criteria.

As a profession and as a society, we cannot afford to sacrifice quality prenatal care. The cost in human potential as well as the cost of care of the compromised newborn would quickly offset the relatively meager cost of the "unnecessary" preventive care.

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Twenty Years: More Questions Than Answers

Non Amo Te

"I do not love thee, Doctor Fell,
The reason why I cannot tell. . . . " – T. Brown

This year we celebrated our 20th year as a duly recognized primary specialty in American medicine. From then until very recently, we were the last primary specialty approved (there were three other "conjoint" types of specialties since 1969 involving several boards as sponsors). In September 1989, the American Board of Emergency Medicine was approved to be converted from a conjoint type of specialty to a primary specialty, making it the 21st primary specialty. Those of our Diplomates who were not on the scene 20 or 30 years ago should know that the specialty of family practice was an unwanted specialty from its very beginning and was born out of adversity. The struggle to be recognized as a legitimate specialty was an arduous and uphill one – every inch of the way.

Back in the early 1960s, it seemed that everyone, including many of our own people, was against us. But we finally prevailed by being persistent and creating the innovations in specialty board genesis. In addition to being the first board without grandfathering Diplomates, we were the first primary

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