

We will try to publish authors' responses in the same edition with readers' comments. Time constraints may prevent this in some cases. The problem is compounded in the case of a bimonthly journal where continuity of comment and redress is difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Premature Labor

To the Editor: The recent article on premature labor¹ does not specify unintended pregnancy as a causative factor, although several of the clues are mentioned, including age, number of children, and short interpregnancy interval. These clues are risk factors for premature labor in themselves, but they are also important as risk factors for unintended pregnancy, which adds an independent contribution to adverse pregnancy outcome. This contribution was well demonstrated in data from the 1982 National Survey of Family Growth: women whose infants were "unwanted" at conception had a low-birthweight rate 36 percent higher than women whose infants were "wanted" at conception (7.9 percent versus 5.8 percent).² Reducing the rate of unintended pregnancies in all women, but especially among women at high risk for preterm birth, has the potential for reducing both the rate and incidence of preterm labor in a very cost-effective manner and could be the most effective single strategy for reducing preterm labor. Recent data from Belgium confirmed that a low level of "investment in pregnancy" (which included maternal attitude toward the pregnancy) was the best predictor of preterm labor, better than traditional risk scoring based upon sociomedical factors.³

The rationale for family planning as a strategy for prevention of preterm labor is derived from the well-documented fact that women at highest risk for preterm labor (and other adverse pregnancy outcomes) are also at highest risk for having mistimed and unwanted pregnancies: poverty, age younger than 18 years, age older than 35 years, parity of 4 or more, interpregnancy interval less than 2 years, and late prenatal care. Aside from the biologic risk factors of age, parity, and interpregnancy interval, there is also a behavioral basis for the effectiveness of family planning in preterm labor prevention in both upper- and lower-income families: women who are not happy about their pregnancy are not likely to seek early prenatal care or to adopt a lifestyle conducive to good pregnancy outcome (including discontinuation of nicotine, alcohol, and other substance abuse), and

they might not be good care givers to the children they bear.⁴

The importance of family planning in reducing rates of preterm labor and reducing perinatal morbidity and mortality has been noted by many studies. The Committee to Study the Prevention of Low Birthweight concluded that "family planning services should be an integral part of overall strategies to reduce the incidence of low birthweight in infants [which is mainly attributable to preterm labor]" and urged that "subsidized family planning funds should be made generously available . . . Title X is specifically targeted at low-income women, including adolescents. As such, the program should be regarded as an important part of public efforts to prevent low birthweight."⁵

In spite of many recommendations for improved family planning services, especially for low-income families, the Reagan-Bush administrations reduced Title X funding by 65 percent, after adjustment for inflation.⁶ The unwillingness of recent Republican administrations to address issues involving sex, sexuality, and contraception constructively is one of the primary reasons that the United States has higher infant mortality rates and higher rates of unintended pregnancies and abortions than any other developed country.⁷

Family physicians are in a unique position to implement the US Preventive Services Task Force recommendation that "sexually active persons who do not want to have children should be counseled about methods of preventing pregnancy"⁸ and can thereby have a substantial impact on premature births, family stability, and public health. Articles in our own journals should not forget the importance of family planning and our particular role in counseling about this important issue.

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References

1. Gjerdingen DK. Premature labor, part I: risk assessment, etiologic factors, and diagnosis. *J Am Board Fam Pract* 1992; 5:495-509.
2. Pamuk ER, Mosher WD. Health aspects of pregnancy and childbirth, United States, 1982. Hyattsville, MD: Department of Health and Human Services Publication (PHS) 89-1992, 1982.
3. De Muylder X, Wesel S, Dramaix M, Candeur M. A woman's attitude toward pregnancy: can it predispose her to preterm labor? *J Repro Med* 1992; 37:339-42.
4. Zuravain SJ. Unplanned childbearing and family size: their relationship to child neglect and abuse. *Fam Plann Perspect* 1991; 23:155-61.
5. Institute of Medicine. Committee to Study the Prevention of Low Birthweight. Preventing low birthweight. Division of Health Promotion and Disease Prevention, Institute of Medicine. Washington, DC: National Academy Press, 1985.

6. Gold RB, Daley D. Public funding of contraceptive, sterilization and abortion services, fiscal year 1990. *Fam Plann Perspect* 1991; 23:204-11.
7. Jones EF, Forrest JD, Henshaw SK, et al. Unintended pregnancy, contraceptive practice and family planning services in developed countries. *Fam Plann Perspect* 1988; 20:53-67.
8. US Preventive Services Task Force. Guide to clinical preventive services: an assessment of the effectiveness of 169 interventions: a report of the US Preventive Services Task Force. Chapters 53 and 54. Baltimore: Williams & Wilkins, 1989.

Roles of Family Physicians

To the Editor: While Dr. Scherger is as thought provoking as always, in his article about family practice models (Models of family practice. *JABFP* 1992; 5:649-53), he errs in assuming that all Kaiser facilities are identical.

Although Northern California Permanente has been slow to appreciate the breadth of family practice training, most of the Southern California Kaiser facilities utilize family physicians in both inpatient and outpatient settings.

At Kaiser Fontana, for example, our family physicians have had full inpatient privileges in medicine, intensive care and cardiac care units, pediatrics, and optional obstetrics for more than 20 years. The majority of the staff at the Fontana medical center practice obstetrics, and in the past year we have expanded privileges to our satellite physicians who wish to practice obstetrics. Our family medicine residents operate three inpatient services with the help of family medicine and internal medicine attending physicians.

In the outpatient setting, the Fontana family medicine department handles all acute surgical and orthopedic trauma cases for the medical center, does its own admissions, and operates subspecialty clinics for colposcopy, vasectomies, minor surgeries, sigmoidoscopies, counseling, and dermatology.

One of the attractions of family medicine training in a Southern California Kaiser facility is the opportunity to learn and use a full range of inpatient, outpatient, and procedural skills from family medicine attending physicians who model these skills in their daily practices.

Irvin S. Roger, MD
Kaiser Permanente
Fontana, CA

To the Editor: In his article, "Models of Family Practice," which appeared in your November-December issue, Dr. Scherger makes several references to Kaiser Permanente and suggests that family physicians in our group model health maintenance organization (HMO) either focus on or are limited to office care. This is simply not true.

Within our Northern California region, we offer family physicians a wide variety of practice settings. At some of our medical centers and clinics, family

physicians have chosen to limit their practice to ambulatory care or emergency department services. At other locations, however, we provide more traditional family practice services, including comprehensive outpatient, inpatient, and intensive care unit care, home care, and nursing home visits. In addition, many family physicians within our group regularly provide outpatient pediatric, gynecological, surgical, orthopedic, and trauma care. Family physicians interested in joining our group are encouraged to speak directly with individual family practice department chiefs about the role of family physicians at a particular facility.

Just as one cannot make broad generalizations about the role of the family physician in our society, one cannot accurately make a blanket statement about the role of the family physician within the Permanente Medical Group. I do agree wholeheartedly with Dr. Scherger that making medical students aware of the rich diversity of practice models available to family physicians (within both HMOs and traditional fee-for-service settings) would make them more likely to choose family practice residencies. No other specialty training gives graduating residents such a wide array of exciting and challenging practice opportunities.

John M. Chuck, MD
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The above letter was referred to the author of the article in question, who offers the following reply:

To the Editor: Generalizing is always very risky, and the letters from Dr. Roger and Dr. Chuck about my essay demonstrate that. I am delighted they have responded to my article pointing out that the Kaiser Fontana facility in Southern California and the Kaiser Fairfield facility in Northern California have an expanded role for the family physician. This information will add to the office-based role for the family physician, which is common in closed-panel health maintenance organizations (HMOs) or multispecialty groups. What Drs. Roger and Chuck and their faculty have done in establishing an expanded role for the family physician in the hospital shows that these roles are not static and can actually move in the direction of greater services for the family physician over time.

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Limits of Technology

To the Editor: The juxtaposition of the two editorials in the September-October 1992 issue of the *JABFP* created some irony. Does the "Parable of the Big Red Bull"¹ apply to ambulatory blood pressure monitoring (ABPM) discussed on the very next page? This is said to cost "\$200 to \$300."²