Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints might 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.

Family Practice Maternity Care

To the Editor: With regard to the recent article by Larimore and Reynolds,[1] I commend the authors for eloquently outlining the barriers encountered by family practice residents seeking training in the delivery of babies. During my recent 1-year family practice fellowship in obstetrics, I also saw firsthand the "demotivation" of family practice residents regarding training in obstetric skills and the incorporation of obstetrics in later practice. My experience with family practice residencies in the Navy has been decidedly different. Having trained in the Navy and now serving as a member of the teaching staff at a Navy residency program, I have seen family practice training programs successfully train family physicians to provide outstanding obstetric care. There are several important reasons why civilian and Navy programs differ.

1. *The patient populations differ tremendously.* In the Navy our deliveries are drawn primarily from the active-duty members and their dependents, a relatively low-risk population. At the civilian hospital where I did my fellowship, the resident teaching cases came from several county clinics and were a mixture of low-risk and some very high-risk populations. Also, the Navy programs are located at community hospitals with level I nurseries. Because of the constraints imposed by our nursery facilities, true high-risk obstetric patients are referred to other hospitals. Because of these two factors the Navy patient population is ideal for family practice obstetrics.
2. *There are no other residency programs at the hospitals where Navy family physicians train.* There is no competition, therefore, with obstetric residents for deliveries. It has been my observation that, generally speaking, family practice residents get the best procedural training when they do not have to compete with other specialty residents.
3. *There is support for family physicians delivering babies at all levels of the Naval hospital command structure.* The family practice department at our hospital provides about 40 percent of the prenatal care and deliveries on a monthly basis. Additionally, family practice residents see patients in the obstetrics clinic and are involved with the care and delivery accorded to all obstetric patients in the hospital.
4. *There is a sense of urgency about learning obstetric skills in the Navy.* Family practice residents must be prepared to go, quite literally, to the ends of the earth and provide prenatal and obstetric care. Most family practice faculty at our teaching programs have been stationed where the family physicians provide primary, in-house coverage for labor and delivery with a backup obstetrician on call. It only takes a few "sea" stories from a staff physician with such experience to convince a resident that the treatment for postpartum hemorrhage and shoulder dystocia will be a part of his or her practice of family medicine.

Most importantly, residents need faculty mentors who are doing the full range of family practice, including obstetrics. In the Navy essentially all family physicians deliver babies. In contrast, at the civilian hospital where I did my fellowship, no family physician on staff delivered babies. Without a strong family practice presence in the labor and delivery suites, there is no counterbalance to the demotivational factors described by the authors. It is time that we, as family physicians, assumed the responsibility for the mentorship of our physicians in training in the care of expectant mothers and the safe delivery of the next generation of children.

LCDR Harry A. Taylor, MC, USNR
Naval Hospital
Jacksonville, FL

References

1. Larimore WL, Reynolds JL. Family practice maternity care in America: ruminations on reproducing an endangered species — family physicians who deliver babies. J Am Board Fam Pract 1994; 7:478-88.

To the Editor: As family physicians at Group Health Cooperative of Puget Sound with busy obstetric practices, we have been touched by how many of our patients after delivery will distill their thanks into two common statements: "Thanks for believing in me," and "Thanks for being there." It is our belief that patients will confer the privilege of attending birth on any qualified provider who embodies the essential qualities of *faith* and *presence*.

At Group Health Cooperative, family physicians, obstetricians, and midwives work together in a well-integrated family-oriented system that honors the diverse needs of its patients while creating an environment of satisfaction and mutual respect for providers. Some of our family physician colleagues who were trained in this system do not provide obstetric care because they do not enjoy it or because they choose to avoid the lifestyle that maternity care demands.

It seems to us a given that family physicians are qualified to provide excellent maternity care services, particularly in settings where specialist obstetricians are readily available. (Of course, this paradigm is really true of all areas of family medicine.) In this vein, we wholeheartedly share the point of view of Larimore and Reynolds in their recent article "Family Practice Maternity Care In America: Ruminations On Reproducing An Endangered Species — Family Physicians Who Deliver Babies" (JABFP 1994; 7:478-88).

Unfortunately, we are very disappointed at the failure of the authors to present a scholarly or even well-written argument. Despite a bold title and an imposing 126 references, the article does not meet evidence-based standards. It is characterized by unsubstantiated opinion, grandiose claims, and trite statements. As a result, the article impedes the advancement of family medicine in the area of maternity care and also calls into question the academic standards of this journal.

Some examples:

1. "... family physicians in rural locations, by choosing not to provide maternity care, might be contributing to an increase in the infant death rate." Despite a cryptic reference to unpublished research, this is an outrageous assertion of possible cause and effect.
2. "Birthing is intrinsic to the formation of the family." This statement is as enlightening as saying we all come from inside our mommies' tummies.
3. "Does family practice have a place in future maternity care in the United States? Absolutely!" Cheerleading statements such as this are interspersed throughout the article and are inappropriate for scholarly writing.
4. A variety of assertions about the quality of family medicine-based maternity care contain multiple references to articles, implying strong substantiation. We are familiar with the cited articles and most of them do not meet rigorous standards themselves.

Let us avoid pseudoscience and anthropologic analogies and condense the article to three points, none of which seems to require referencing:

1. Family physicians can provide high-quality maternity care.
2. Insofar as family physicians are the only providers who can provide true continuity of care for mothers, infants, and families, we have something unique to offer to an integrated system of maternity care.
3. Lay persons and professional providers working together need to form better integrated systems of maternity care in the United States.

Michael P. Madwed, MD
Karin T. Madwed, MD
Group Health Cooperative of Puget Sound
Seattle, WA

The above letter was referred to the authors of the article in question, who offer the following reply:

To the Editor: We are pleased that Drs. Madwed and Madwed enjoy an active practice in childbirth care, that they have the blessing of practicing in a supportive environment, and that they recognized the hyperbole of our paper. Their last three points are an excellent summary of what we have written.[1]

The Madweds might have misread us, however. We did point out that there is an *association* between infant mortality and physician availability in the rural counties in Indiana and Florida, based on a published work by Allen and Kamradt[2] and an unpublished work by one of us (WLL). As the Madweds must be aware, associations in no way imply cause and effect. In fact, we said, "if these data represent a cause and effect... then we must insist that family physicians remain involved or become involved in rural and underserved areas."[1]

Any astute observer of maternity care in America understands that the "birthing" of a baby and the "delivery" of a baby are distinctly different processes — by history, philosophy, function, nature, cost, and outcome. We,[3-5] as well as others,[6,7] have more completely discussed these observations.

The Madweds feel that the encouragement of maternity care by family physicians does not need cheerleading. We believe that view can only be held by those who are in protected environments and who have neither seen nor heard about the persecution and pain that many family physicians experience who desire to or try to include maternity care in their practices but cannot. Recent literature has addressed these phenomena further — particularly as they relate to the eastern and southern parts of the United States.[8-10]

To be accused of "not meet[ing] evidence-based standards" when the "imposing . . . references" we drew upon, for the most part, fail to do so, is not totally unexpected. But a critical review of these references will show that the majority of evidence-based articles come from "family practice" journals. As so very little of standard obstetric practice has anything to do with evidence-based medicine, we chose not to be too exceptional. Furthermore, we would guess that if the Madweds and most other maternity care providers critically reviewed their practices of maternity care, they would find a variety of beliefs and practices that have no evidence-based substantiation.

We regret the Drs. Madwed are embarrassed by our passion and that somehow enthusiasm is equated with being unscholarly. All science and all scholarly writing done by human beings is by definition subjective. Only those who have no real grasp of the philosophy of science or of epistemology could be taken in by the illusion of objectivity.

Skepticism has its place, but it should not blind us to the experience of truth.

Walter L. Larimore, MD
Kissimmee, FL
J.L. Reynolds, MD, MSc
London, Ontario