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 a bimonthly journal where continuity of comment and redress are 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.

Procedures in Family Practice

To the Editor: It might be in the eye of the beholder. A family physician ethicist who looks at procedures reflects on ethical issues. The family physician who is procedurally oriented views the development of new primary diagnostic and therapeutic procedures as a logical extension of the domain. The family physician ethicist reflects on the appropriateness of incorporating a new procedure into practice. At a time when other disciplines are expanding their turfs, it is important that family practice not only "be proud of what is unique" but also address what is common in ambulatory primary care. Long before there was a specialty board for family practice, general practitioners were performing rigid sigmoidoscopies, uterine dilation and curettages, and cervical conizations. As the discipline has advanced, more refined office-based approaches have been developed to examine and treat these areas.

In their recent article "Family Physicians as Proceduralists: Striking a Balance" (JABFP 1995; 8:58-61), Brody and Alexander define high-quality practice as a "less costly and often more elegant low-tech, high-touch approach." Examining orifices, however, has always been part of the field of family practice. If a person has ear pain, it is appropriate to use an otoscope to examine the ear. I believe that when symptoms direct or guidelines recommend, other apertures should be appropriately evaluated. If accepted clinical guidelines recommend a flexible sigmoidoscopic examination every 5 years after the age of 50 years or a colposcopic examination to follow up an abnormal Papanicolaou smear, it is appropriate for a trained family physician to perform the examination. The primary motivation should be the patient's benefaction. Secondary motivating factors can include the satisfaction from doing procedures or the preferential reimbursement for procedures.

The argument that the physician performing one's own procedures is a form of self-referral is appropriate to consider. In a similar manner, however, physicians recommend comprehensive examinations and return interval visits to monitor chronic disease or to promote health maintenance, which are also self-referrals that can be appropriately made or generated to assist in paying the rent. The issue relates to the medical appropriateness of the procedure or office visit.

In the past, as in the present, procedures have generated more income than have cognitive visits. There are loss leaders, low-ticket and high-ticket items, in all businesses. A physician with a balanced practice will compensate for the disparity. I agree with Brody and Alexander that our specialty can "work to develop more explicit guidelines on how many and what sorts of procedures family physicians must do to be competent." Because failure to diagnose is a frequent malpractice issue for family physicians, it is extremely important to practice according to current guidelines. In addition, family physicians should be involved in the development of guidelines concerning the appropriate indications for procedures. I do not believe, however, that family physicians should only "perfect their eyes, ears, and interpersonal skills" to diagnose patient problems. If family physicians are to provide comprehensive care for patients, they should also be skilled "to use machines," such as the stethoscope, otoscope, sigmoidoscope, and colposcope. The expense for the patient or system will be there whether the personal physician performs the procedure or refers the patient to another physician.

In summary, I believe that it is appropriate for family physicians to be trained in the office-based procedures commonly performed on ambulatory patients. Appropriateness and competence must meet not only the standards of our discipline but of medical practice in general. The primary motivation should be maintaining the well-being of the patient and family.

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To the Editor: I appreciate the thoughtful commentary of Brody and Alexander on family physicians as proceduralists.[1] The authors are exactly right in recognizing the need to strike an ethical balance. I assume their article is meant to focus on "high-tech" procedures, or what I would call bigger procedures, such as colposcopy and sigmoidoscopy. In that regard, I would agree that teachers or practitioners should never overemphasize procedural skills to the neglect of interpersonal or patient care skills. In an effort to place bigger procedures in the appropriate context, however, we should not forget that the smaller, "low-tech" procedures form an integral part of our "high-touch" profession.

As Carmichael[2] points out, procedures such as removing ear wax or trimming toenails are excellent ways of caring for patients. We family physicians are intimate with our patients, and the more skilled we are at touching them, examining them, and doing things for them with little or no discomfort, the more we strengthen the physician-patient bond. Seemingly minor things, such as injecting local anesthetics in a way that minimizes discomfort, can deepen a patient's appreciation of a physician's skills.

The philosophy of our family practice residency program is that good family physicians use their hands. Learners are taught to be comfortable touching patients' bodies and to pay attention to doing the little things for patients that add to the intimacy of the visit. We also try to provide opportunities to acquire skills in the bigger procedures — colposcopy, sigmoidoscopy — but that is of secondary importance. We teach our learners to use their hands because it makes them better physicians.

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References

1. Brody H, Alexander GP. Family physicians as proceduralists: striking a balance. J Am Board Fam Pract 1995; 8:58-61.
2. Carmichael LP. A different way of doctoring. Fam Med 1985; 17:185-7.

Obstetrics in Family Practice

To the Editor: I am writing in response to the article by Walter L. Larimore and James L. Reynolds regarding family practice maternity care in America.[1] As a family physician who both practices and teaches family-centered maternity care, I appreciate the authors' summary of the recent medical literature regarding this topic. I agree strongly with their conclusions that family physicians have an important place in providing maternity care, which we need to emphasize further in our residency and fellowship programs.

I further agree emphatically that even as we strive to train ourselves technically, we need also to learn from our colleagues in midwifery regarding more "low-tech, high-touch" care, so that we do not become merely mini-obstetricians. I have some thoughts regarding jumping on the midwifery bandwagon, however. First of all, it is my sense that by definition nurse midwives come to their practice from a very different paradigm of care for the patient, with much more emphasis on hands-on, moment-to-moment comforting measures than physicians get in their medical training (where, for example, changing soiled linens or stroking a patient's forehead with cool cloths is not considered "the doctor's job"). As we seek to understand and incorporate such labor support into our routines of intrapartum care, in hopes of lowering operative intervention rates, we need to be able to redefine or reallocate these traditional roles.

Second, as Drs. Larimore and Reynolds mention, another big difference in training for midwives versus family physicians is that most midwives "have no previous knowledge of the woman or her family and do not provide ongoing care to the newborn child."[p. 481] I think this difference is critical and must be emphasized strongly in terms of what family physicians can do differently in caring for women and their families. This cross-generational longitudinality of care is the crux of family medicine and is what makes our potential for family-centered maternity care so unique, what makes us not only more than mini-obstetricians but also more than mini-midwives. In my professional and personal experience with midwives, even those most attuned to labor support issues miss opportunities for a true family orientation to perinatal care; e.g., by not addressing the father's or grandmother's concerns or interests at a prenatal visit. A family physician's training in taking genograms could in a prenatal interview elicit valuable psychosocial information regarding both parents' families experiences with pregnancy and childbirth.

Thus I think while we have much to learn from midwives regarding labor support and "low-tech" perinatal care, we also have much to teach them (and our obstetrician colleagues) about truly family-centered care.

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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: Congratulations and thanks to the *Journal* for publishing the article by Larimore and Reynolds[1] and the accompanying editorial by Borst[2] dealing with obstetrics in family practice. These writings should be required reading for medical students on their family practice clerkships, family practice residents, and also for our own faculty as a source of balance or reinforcement against the learned helplessness that still unfortunately pervades the medical education system. Although many of the points made in the article are "givens" to those family physicians who include perinatal care in their practices, this collection of historical perspective and point-by-point discussion of the issues of obstetrics within family practice, presented in an upbeat style, is just what is needed to balance the negative recruitment our trainees face in academic centers.

Hidden in the article and implicit in the historical perspective of the editorial is an important issue that deserves much more attention by researchers: How does family physician participation or nonparticipation in perinatal care contribute to maternal-child health or morbidity? A recent study of this issue by Larimore and Davis[3] should spur others to look at their particular practices and geographical areas for answers. Perhaps further study will show that well-trained family physicians can succeed where regionalization of perinatal care according to the subspecialty model has failed to reduce perinatal mortality and morbidity in many geographical areas. Favorable data would provide needed chips for the academic center games our trainees must play and ammunition for the hospital privilege battles that our graduates face.

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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.