

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

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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.<sup>1</sup> 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."<sup>2</sup> 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<sup>1</sup> and the accompanying editorial by Borst<sup>2</sup> 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<sup>3</sup> 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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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.

2. Borst CG. Obstetrics and the family physician: a medical historian's perspective. *J Am Board Fam Pract* 1994; 7:530-4.
3. Larimore WL, Davis A. Relationship of infant mortality and low birth weight to the availability of pregnancy care in rural Florida. Presented at the Annual Meeting of the Society of Teachers of Family Medicine, Atlanta, GA, 2 May 1994.

#### Immunization Rates

*To The Editor:* Congratulations to Alto, et al.<sup>1</sup> for their informative study regarding the effectiveness of mail and telephone contacts to improve vaccination compliance. We attempted a similar study but stopped after we discovered our vaccination rate was quite high compared with the national average (11 to 55 percent); median, 44 percent.<sup>2</sup>

We analyzed our population at Schofield Barracks, Hawaii, in an attempt to quantify the percentage of children completely immunized. We proceeded on the presumption that our population was about as well immunized as the general civilian population, and we wanted to test particular interventions (such as telephone calls, letters, and campaigns in the post newspaper) to see whether they had any effect on immunization compliance.

We began by collecting, with the help of our Composite Health Care System (CHCS) — (the computer system in which every military beneficiary on Oahu is registered), the names of all 14- to 15-month-old children whose charts were at Schofield Barracks Health Clinic. (We collected charts of only 14- and 15-month-old children to assess immunizations during the first year. In our highly mobile military population, trying to assess more was considered unrealistic.) Of the 64 charts available for review, 49 were considered complete (defined as having completed all required shots at 2, 4, and 6 months, and the tuberculin test [only] at 12 months. We counted the hepatitis B series shots but did not include it in our definition of complete, because it is, at this point, only recommended and not required.) Telephone contact was attempted for all patients whose records were incomplete, and only 8 children were found to be behind in their immunizations. The parents of 7 children could not be contacted because of moves or wrong or disconnected telephone numbers.

The numbers indicate that 49 of 57, or 85 percent of our patients, had completed their immunizations by 15 months of age. Even if we assume that all 7 of those patients with whom no contact could be made had incomplete charts, the immunization rate is still high at 77 percent (49 of 64). Unfortunately, only 18 of 57 (31.5 percent), finished their hepatitis series. Interestingly, 48 began the hepatitis series, but only 18 saw it through completion.

Although we were disappointed with the hepatitis immunization rate, we were so surprised with the excellent result obtained by our required shots screening that we decided not to pursue any focused intervention, as it probably was not going to improve our compliance much, if at all.

Reasons for our unexpected excellent compliance might include free immunizations, relatively easy access to our immunization clinic, the emphasis of preventive care practiced by our health care providers, or that all child care centers on post refuse to admit youngsters without documented proof of immunization. In addition, we did not account for the required fourth dose of diphtheria-pertussis-tetanus (DPT). It was noted by Bobo, et al.<sup>3</sup> that compliance was 10 percent greater if the fourth DPT was excluded, which our study might reflect.

We also noted that we missed many opportunities to protect children against hepatitis. The hepatitis immunization rate improved once our providers and our immunization clinic became aware of this shortcoming and became more aggressive in immunizing youngsters.

It is encouraging to see studies, such as that by Alto, et al., which actually do show a difference in compliance rates with specific interventions. We encourage other family physicians — especially those with "closed" patient populations — to check their own immunization compliance rates and implement appropriate interventions. Perhaps with stricter enforcement by preschool and elementary school authorities that all immunizations be up to date, we can improve our dismal record of immunization compliance.

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#### References

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2. Zell ER, Dietz V, Stevenson J, Cochi S, Bruce RH. Low vaccination levels of US preschool and school-age children. Retrospective assessments of vaccination coverage, 1991-1992. *JAMA* 1994; 271:833-9.
3. Bobo JK, Gale JL, Thapa PB, Wassilak SG. Risk factors for delayed immunization in a random sample of 1163 children from Oregon and Washington. *Pediatrics* 1993; 91:308-14.

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

*To The Editor:* Drs. Crisp and Clark are to be congratulated on their achievement of an 85 percent immunization coverage by 15 months within a military-dependent population. It would be of interest to determine why the other 15 percent of these toddlers were not completely immunized. The answers to this question might allow them to improve on their already excellent accomplishment.

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