

Dr. Allen should also be congratulated for the extra time and effort required to submit such an article. He continues to exhibit those qualities that made him an outstanding resident at our Army community hospital.

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To the Editor: I read the article by Dr. Allen¹ with great interest. It is a pleasure to read about a rural family physician still practicing obstetrics and providing excellent obstetrical care. This is even more heartwarming because he does this with anticipatory guidance, identifying the high-risk pregnancy and seeing that appropriate care is provided.

The United States Cesarean section rate climbed to 22.3 percent in 1986, and this percentage was closely followed by Canada and Australia.² Of the 19 countries compared (with the exception of Canada and Australia), the U.S. rate was 50 to 200 percent higher than that of other countries. Dystocia contributed to 30 percent of the rise in Cesarean birth rates from 1970 to 1978, and repeat Cesarean accounted for 25–30 percent of this rate increase. Breech presentation and fetal distress each accounted for 10–15 percent of the remaining known causes for the increase.³

Doctor Allen clearly presents how he kept his Cesarean rate down by giving his patients with previous sections a trial of labor. He also lessened the probability of section in patients with breech presentation by arranging an external version to be done by an obstetrician, who then referred the patient back to him for continuing prenatal care and vertex vaginal delivery.

I would like to quote his fourth summary point because I believe it also is likely a factor in lowering his CS rate. "I strongly encourage childbirth classes, partner participation, and natural childbirth."^{1(p 32)} With a supporting partner and supporting family physician, Dr. Allen's patients are better informed and better prepared for childbirth. His patients are less anxious at labor, have more effective contractions with less pain, fewer epidurals, resulting in less dystocias, and thus, with a nonaggressive supporting family physician, are less likely to receive Cesarean sections.

There are two studies that showed a number of significant differences in quality of care between obstetricians and family physicians that I would like to bring to the attention of *Journal* readers. Klein, et al.⁴ reported that induction was carried out more frequently in the shared-care (consultant) system, particularly in multiparous women, for whom the rate was 27 percent compared with 10 percent in the general practice unit (GPU) ($P < 0.001$). Epidural analgesic was used more frequently in nulliparous women in the shared-care system than in those booked for the GPU (17 percent and 5 percent, respectively) ($P < 0.001$). Forceps delivery was more common in the women booked for shared-care than in those booked for the GPU; the respective frequencies were 36 percent and 28 percent in

nulliparae ($P < 0.05$) and 8 percent and 1 percent in multiparous ($P < 0.001$).

In his second study, Klein, et al.⁵ reported that both the first and second stages of labor were longer for women in the GPU but they received less pethidine ($P < 0.01$), and fewer had epidural analgesic ($P < 0.02$). These women also received less electronic fetal monitoring, augmentation, and forceps delivery. The 1-minute Apgar score was < 6 in 17.5 percent of infants of nulliparae in the shared-care system compared with 1.6 percent in the GPU ($P < 0.01$). The intubation rate of infants of nulliparae was 11 percent in the shared-care system compared with no intubations in the GPU ($P < 0.01$). The authors concluded that deliveries of low-risk women in the GPU, when compared with deliveries of similar women in a shared-care (consultant) unit, are simple and safe.

I believe it is important for family physicians to continue to practice obstetrics, because low-risk patients need a conservative, low-technology approach.

I suspect prematurity is a minor problem in Dr. Allen's practice because of his anticipatory guidance and approach of identifying the high-risk pregnancy and taking preventive action by using the WIC and other community resources for those patients who need it. Identifying the high-risk pregnancy early, along with proper team management throughout the prenatal period, does make a difference in neonatal morbidity and mortality.⁶ With regionalization of perinatal services, it is possible to reduce the perinatal mortality rate in small community hospitals to levels that approximate those in sophisticated tertiary care hospitals.⁷

In order to make this system work, it is important for family physicians to have an efficient screening system for identifying high-risk pregnancies and to arrange early consultation and referral.

Dr. Allen is to be commended for keeping records and presenting his approach as a rural family physician practicing rural obstetrics. Hopefully, his report will stimulate other rural family physicians using the team approach to obstetrics to publish their experiences. It may even stimulate some urban or suburban family physicians to make comparative studies.

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References

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To the Editor: I am responding to the article by Dr. Wain Allen about rural obstetrics. I applaud Dr. Allen for his efforts in this worthwhile part of family practice and also applaud his successes as evidenced by his study. It is refreshing to see other family physicians who have not yet abandoned the practice of obstetrics. There is a real "bonding" between the family physician and the family when childbirth occurs.

Because obstetricians, in both specialties of OB-GYN and Family Practice, are dropping the practice of obstetrics in increasing numbers, this would be an excellent time for our specialty to encourage our residents to consider this valuable part of family practice and stake our claim there. We can definitely do no harm, in the public's eye, to our image by providing a quality service, which is harder and harder to obtain.

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Decubitus Ulcers

To the Editor: Perdue and Wilson have written an excellent review of decubitus ulcers (January-March 1989). They have covered a variety of treatments but have neglected prevention. They have shown that with fluid support, which distributes weight uniformly over the largest possible area of surface contact, skin pressure still equals or exceeds capillary pressure, resulting in anoxia of the skin. When operating on a limb in a bloodless field, we are taught to release the tourniquet briefly every hour. Similar relief of skin pressure results from turning the patient from side to side; every 2 hours is the standard because this is the longest period usually tolerated, and the attendant's time costs money. When a worker is late or absent, the chart will still document

"turned every 2 hours," and we may wonder why a decubitus ulcer was noted a few days later.

Many lawsuits are filed by children of elderly patients. The children feel guilty of neglecting the parent who has been placed in a nursing home, and the lawsuit is an attempt to shift their guilt to the doctors and the nursing home.

Automatic recordings of sleeping persons show movements to change position every 5 or 10 minutes. Sensory or motor impairment that prevents these spontaneous movements makes decubiti likely.

The alternating pressure air mattress that changes the areas of skin pressure every 3 minutes has been described as very effective. However, placing a foam pad on top of it will tend to restore uniform pressure and negate its effectiveness. Some air-support beds that appear to provide uniform pressure probably work by the turbulence of air that allows intermittent blood flow to all areas of the skin.

An even better device is a mattress that automatically and gently turns the patient from side to side at any desired interval. This product is available commercially.

Many elderly people have such fragile atrophic skin that a shearing force that would normally produce only an abrasion in others will give them a gaping laceration. However, to produce an ulcer, this shearing force is not enough: pressure ischemia must first have devitalized the skin.

To prevent decubiti, either more intensive nursing care, with turning at least every hour, or one of the mechanical devices to relieve skin pressure at more frequent intervals is needed.

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Corrections

The Consultant Family Physician (January-March 1989; 2:35-6). In Table 2 and Table 3, under the heading "Reason," the phrase "For a procedure I do" should have been "For a procedure I do not do."

Editors' Note (January-March 1989; 2:3). "Hartman, Bill, M.D." should have been "Hartmann, William, M.D." We regret the error.