Editorials

Prenatal Care – A Serious National Dilemma

Recently, a blue-ribbon committee of obstetricians released a public announcement that, after deliberate study, they concluded that some pregnant women eligible for federal entitlements need not receive as many prenatal care visits as they have in the past. It was believed the costs for the care of pregnant women who are at low risk for complications might be excessive.

Some practicing physicians have found this announcement to be rather startling. While the majority would agree that controlling the costs of federal entitlement programs is probably sound economically, many would question the wisdom of reducing support for appropriate preventive care. This would seem especially problematic in prenatal care. Comparisons with outcomes of pregnancy in other countries clearly suggest that the United States needs to improve the quality and quantity of prenatal and perinatal care.

Concern has been expressed that further reductions of the meager incentives to provide quality prenatal care could result in even higher rates of prenatal morbidity and mortality. However, at the same time, physicians cannot ignore the possibility that they might be "over-doctoring" some patients. There is a persistence of the dilemma in national policy that tries to balance quantity, quality, and cost. If one of these three variables changes in a positive direction, one or both of the other two variables must change in an adverse direction.

Aside from the micro- and macroeconomic issues, the practitioner must ultimately decide what is best for the patient. Are there sufficient data to predict an appropriate frequency and timing of prenatal care visits? Should this question be addressed by a massive multisite primary care study? If such a study were done, would society be any closer to resolution of the dilemma of cost versus quality versus quantity? The number of variables to be considered is significant. Our ability to measure some of the variables is limited, e.g., cultural background, health beliefs, and family influences.

Irrespective of national policy, the physician retains the ultimate responsibility for the provision of prenatal care. Sound scientific principles tempered by a thorough understanding of the patient and family in the context of the community environment must be applied assiduously. Physicians must not be seduced into ignoring the individual needs of the patient or the intrinsic value of the doctor-patient relationship. Prenatal visits should not be reduced to a perfunctory assessment of physiologic criteria.

As a profession and as a society, we cannot afford to sacrifice quality prenatal care. The cost in human potential as well as the cost of care of the compromised newborn would quickly offset the relatively meager cost of the "unnecessary" preventive care.

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Twenty Years: More Questions Than Answers

Non Amo Te

"I do not love thee, Doctor Fell,
The reason why I cannot tell. . . . " – T. Brown

This year we celebrated our 20th year as a duly recognized primary specialty in American medicine. From then until very recently, we were the last primary specialty approved (there were three other "conjoint" types of specialties since 1969 involving several boards as sponsors). In September 1989, the American Board of Emergency Medicine was approved to be converted from a conjoint type of specialty to a primary specialty, making it the 21st primary specialty. Those of our Diplomates who were not on the scene 20 or 30 years ago should know that the specialty of family practice was an unwanted specialty from its very beginning and was born out of adversity. The struggle to be recognized as a legitimate specialty was an arduous and uphill one – every inch of the way.

Back in the early 1960s, it seemed that everyone, including many of our own people, was against us. But we finally prevailed by being persistent and creating the innovations in specialty board genesis. In addition to being the first board without grandfathering Diplomates, we were the first primary

board to have representatives of other specialties sit on our Board of Directors. We have currently an internist, a pediatrician, a surgeon, an obstetrician, and a psychiatrist, in addition to 10 family physicians who make up our Board of Directors. We also were the first specialty board to have time-limited certification, i.e., *mandatory periodic* recertification to maintain Diplomate status. I really believe the latter two elements, that is, a multidisciplinary board and recertification, are what favored us in eventually getting approval of the specialty within a hostile environment.

Etched in my memory is the rooted resistance to this new specialty and some of the aspersions therewith, i.e., "LMD" as a reference for a general practitioner or the slur "just a G.P." Today, a lot, but not all, of the antagonism is gone. Our plan from the beginning was not to get into mudslinging but to strive for excellence in our training programs, swearing never to mediocrity. By our works, other specialties would come to respect family practice. Quite frankly, it's been working to a large degree. We acknowledge there is still quite a way to go but believe that we've been going in the right direction. However, it seems that in the last year or two we've come to a standstill and may actually begin to lose ground soon.

I remember some long evenings of discussion with those few renegade G.P.s who helped get this specialty going. Many of them became weary of the frustrations and dropped out of the movement, but a few of us stayed in there, and from nearly ground zero in 1969 to today, we have over 380 accredited residency training programs with over 7200 residents currently in training, as well as 37,000 Diplomates actively certified. Yes, we have come a long way. Other specialties are beginning (slowly) to realize our true worth. Yet in spite of our successes, I ween, we should have been further along in 20 years. Why has our growth leveled off at a point that we believe should be merely halfway?

Our primary goal in 1969 was to achieve clinical credibility within the first 10 years of our existence. We have done that; even our enemies concede our trainees are competent physicians. Our secondary goal was to achieve academic credibility within 20 years. This, I believe, is where we have fallen short. Yes, there are family practice departments in most medical schools, but how many are "token" departments? I personally am disappointed that in 1989 there is still widespread derision of family practice among the faculties of medical schools across the nation. Why aren't more than 12 percent of medical school graduates going into family practice? Certainly, other "primary care" specialties are feeling the pinch, but family practice currently has more to offer than *any* primary care specialty. Even if all the graduates who are now going into "general" medicine or "general" pediatrics went into family practice, would there still be sufficient numbers of family physicians for the nation?

Why haven't we achieved the academic credibility we planned by 1989? There are many reasons that come to mind, but there loom questions in my mind: Are we really deserving of academic credibility? Do we really have the leadership among our faculties that we should have? Are there many catachrestic F.P.s in medical schools, submitting to the will of inimical oppugnant deans?

Even in 1989, one goes to meetings and hears the declamations for comprehensive care, ambulatory teaching, and prevention uttered as if they were "new" ideas of some suddenly enlightened professoriate—all of which we espoused loudly and clearly many years ago,[1] yet nary a word acknowledging family practice in those lecture halls.

Should we continue the way we have, pressing on, insisting only on high-quality programs, valid examinations, and meaningful recertification procedures? By so doing, can we win the struggle to bring to the American people—perhaps all people eventually—superior and comprehensive health care? How long do we sit helplessly observing the deliquescence of primary care while the procedural and more profitable specialties proliferate? How do we get dedicated young people, who aspire to be ministrant while earning a very worthy living, to cast a look our way?

How can we bring back medicine to its once held position as a *revered* profession? Has the 20-year struggle (with more than a modicum of success) reached its climax? Is it time for some *serious* talk among our colleagues who are deemed leaders in family practice organizations to meet and develop an agenda for *aggressive* action, for, indeed, as the Bard has said, "Action is eloquence"? The accomplishments of family practice in the

last 2 decades must only be a beginning – let's not entrench ourselves into a chronic holding position. We "must mix with action, lest than [we] wither by despair" – Tennyson.

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References

1. Pisacano NJ. Generally speaking. JAMA 1970; 213:432-3.

Fin de Siècle: Four Modest Wishes for Family Practice

Except for a few centenarians, who happened to be born in the 1880s or 1890s, we have the once-in-a-lifetime chance to live in the last decade of a century; rarer still, that decade also concludes a millennium. Such times might not be more portentous than others, but they stir our sense of history and whatever proclivities we harbor for numerology and spawn a good deal of reflection and prediction – some of it apocalyptic. *The Timetables of History*[1] suggests that there was widespread fear of "The End of the World" and the "Last Judgment" in the 990s, but there are only two entries of consequence under the heading "Science, Technology, Growth." One is that Leif Ericson is given credit for discovering Nova Scotia, and the other is the recognition of the importance of zero in mathematics.

By contrast, the 1890s (The Gay Nineties a.k.a. The Gilded Age) showed no evidence of apocalyptic anxiety and were replete with discoveries and inventions, some of which, as they unfolded in the twentieth century, had more apocalyptic potentiality than anyone imagined. The discovery of radioactivity, radium, and polonium and the invention of quantum theory in physics and the principles of rocket propulsion led, indirectly, to "The Bomb." One can hardly avoid observing the irony that people were less afraid of the future when they had more reason to be.

Perhaps they were enamored of more promising inventions in aircraft design (Zeppelin), the Diesel engine, the automatic telephone switchboard, cinematography, wireless telegraphy, and the horizontal gramophone disc. In medicine, the 1890s gave us x-rays, antitoxins, the organisms responsible for plague and malaria, Freud's "Studies on Hysteria," and the first use of rubber gloves in surgery. Small wonder that the last *fin de siècle* was a time of optimism and that no one could foresee two world wars, the Holocaust, freeways, laser discs, man-made satellites, organ transplants, magnetic resonance imaging, and AIDS, even though all were nascent then.

I have no capability or intention to predict what the 1990s will bring in science and technology that might affect the twenty-first century in similarly amazing ways, but surely I cannot be blamed for indulging in lesser speculations about our small part of human experience, our vocation as family physicians. The beginning of a new year is a traditional time for resolutions and good wishes, so in this first month of the first year of a decade that will usher in a new millennium, I have the temerity to make four modest wishes. None has ominous implications for the world-at-large, but they could be important for the next step in the evolution of medical practice in the United States.

Four Wishes

A Family Physician for Every Citizen

Without quarreling about names and titles in primary care, I wish that every citizen could have easy access to the medical services of a family physician, services that were envisioned and described in 1966, in "Reports" that are now familiarly known as Millis, Folsom, and Willard. Our nation has not yet made good on their ideals, which are still valid and widely accepted in principle. Each citizen deserves to be known by name to an identified physician who will provide ordinary medical services of high quality in the citizen's community, who will obtain consultation and make referrals to the next level of expertise, and who will buffer the citizen against nonrational encounters with the medical bureaucracy and the medical supermarket.

Achieving this wish will require further efforts to value this role and to prevent its erosion by unconscionable debt, unreasonable liability, and absurd professional constraints and to make it as attractive and gratifying as its natural affinities have always allowed. The role itself needs no artificial "hyping" or sales ability, because it is rooted in human nature, tribal and civilized history, and moral sensibilities. Hippocrates is