Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints may prevent this in some cases. The problem is compounded in the case of a quarterly journal where continuity of comment and redress is difficult to achieve. When the redress appears 3 months after the comment, 6 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.

Prenatal Care

To the Editor: In the editorial, "Prenatal Care – A Serious National Dilemma," (J Am Board Fam Pract 1990; 3:63) Dr. Paul R. Young suggests that, "As a professional and as a society, we cannot afford to sacrifice quality prenatal care," and he is rightly concerned that this care, "not be reduced to a perfunctory assessment of physiological criteria." He expresses concern about the recent suggestion by the Expert Panel on the Content of Prenatal Care[1] to decrease the number of prenatal visits for low-risk women. We believe that this recommendation must be viewed within the context of the report.

Dr. Young is mistaken when he states that the Panel was "a blue-ribbon committee of obstetricians." The Panel was a truly multidisciplinary group and included public health, nurse midwife, psychiatry, health education, and *family medicine* representation. Also, the panel emphasized – indeed, put on the national prenatal care agenda – many of the philosophical principles for which family medicine has advocated for more than 20 years. Among others, the Panel concluded the following: (1) that psychosocial dimensions of care should be added to the traditional medical concerns and that a balance should be maintained between these factors; (2) that the basic components of prenatal care are: (a) early and continuing risk assessment, (b) health promotion, and (c) medical and psychosocial interventions and follow-up; (3) that preconception care should be an integral part of prenatal care (They stated that primary care physicians are in the best position to deliver this care!); and (4) that the objectives of prenatal care are to promote the health and well-being of the pregnant women, the fetus, *the infant, and the family up to one year after the infant's birth.*[1,2]

This report encourages physicians to include broadly defined psychosocial risk factors in evaluating risk status. "Front loading" prenatal care was emphasized by the Panel so that psychosocial risks such as smoking, alcohol use, nutritional problems, homelessness, financial concerns (and many others) could be identified and treated early in pregnancy.

Obviously, for women at high medical or psychosocial risk, more visits are needed throughout pregnancy, particularly early in pregnancy to coordinate this care. The report puts less emphasis on visits later in pregnancy for women at less medical and psychosocial risk. This recommendation is based on the extant evidence regarding the timing and frequency of visits, which indicates no increased benefit of a greater number of visits for low-risk women. Unfortunately, this part of the report received particular media attention and scrutiny from the specialty boards.

Dr. Young rightly notes that Americans should be concerned with the contrast of the outcome of pregnancy in the United States with other countries. We are last among developed nations with regard to our neonatal and infant mortality rates. Testimony presented to the Panel by a representative of WHO noted that no relation exists between such pregnancy outcome rates and the number of prenatal visits recommended in various developed countries. Several striking differences do exist between other developed countries and the United States. All have national systems that guarantee health care to all pregnant women, all place greater national policy emphasis on providing for the social well-being of pregnant women and young mothers, and all have most prenatal care provided by midwives or general practitioners rather than obstetricians. The WHO Perinatal Study Group suggests a system of reduced prenatal visits combined with other forms of social support for pregnant women.[3]

Many psychosocial risk factors are related to poverty. Women at increased psychosocial risk often have few resources to pay for these visits, and women at low psychosocial risk often have resources to afford additional visits. Women at increased psychosocial risk are in particular need of increased counseling and supportive interventions from their family physicians or other caring personnel working closely with physicians. Such interventions may or may not take the form of additional visits. However, for the low-risk woman who is comfortable and secure in her health during pregnancy, not all the visits currently recommended may be necessary. This is particularly true for the woman who has received from her family physician the extensive early pregnancy risk assessment and education and health promotion recommended by the Panel. We must reallocate resources to emphasize visits that are effective toward reaching the goals of prenatal care, and we must reduce emphasis on visits that are less effective toward reaching these goals.

We hope that advocates of prenatal care will base their opinion of this report on a balanced analysis. It is our opinion that this report is a step in the direction of flexible and enriched prenatal care that is sensitive to the needs of women, children, and families.[4]

Brian W. Jack, M.D.
Larry Culpepper, M.D., M.P.H.
Pawtucket, RI

References

1. Caring for our future: the content of prenatal care. A report of the Public Health Service Expert Panel on the Content of

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Prenatal Care. Department of Health and Human Services. Washington, D.C., 1989.
2. Culpepper L. Obstetrics and family practice: report of the Expert Panel on the Content of Prenatal Care. Fam Med 1989; 21:333-5.
3. Having a baby in Europe. World Health Organization Regional Office for Europe. Copenhagen, 1985:73-6.
4. Institute of Medicine. Preventing low birthweight. Washington, D.C.: National Academy Press, 1984.

Editor's Comment

I sincerely appreciate the comments of Drs. Jack and Culpepper and stand corrected regarding my factual errors. However, I suspect I am not alone in misinterpreting the public information, which was provided through the media. This explanation helps me to feel much more positive about the suggestions of the Expert Panel. Nevertheless, I continue to be haunted by a palpable uneasiness about prenatal care in this country. I share the hopes and aspirations of the Panel and applaud their efforts.

Paul R. Young, M.D.
Lexington, KY

Mammography

To the Editor: Dr. Foley, et al. report an increase in the performance (from 35 percent to 45.2 percent) of mammography in a hospital-based family practice teaching service as the result of a nurse-initiated intervention.[1] Theirs is one of the few studies to have reported physician offer rate, and for this they are to be commended. They state that, unfortunately, less than 50 percent of eligible patients had mammography recommended. From this comment, and the 45 percent performance rate, it appears that patient refusal was a minor factor.

An important observation made in their article was that one barrier to physician offer of mammography was "meeting the patient for the first time or treating the patient for an acute unrelated problem." In light of this comment, it is unfortunate, therefore, that they purposely eliminated this group of patients from analysis in their study. Of the 387 postintervention charts available for analysis, they eliminated 117 (30 percent) because they did not meet the criteria of being "an established patient receiving continuity of care at the health center." It would be interesting to know the screening experience of the new or episodic patients who appear to compose one-third of their practice. I would guess that screening activity for this group is not very good.

I would agree with the authors' expectation that the proportion of eligible women having mammograms recommended will increase after their intervention has been in operation longer. I suggest that they, and all of us, extend our concept of eligibility to *all* women, including those patients seen infrequently or for the first time.

David L. Hahn, M.D.
Madison, WI

References

1. Foley EC, D'Amico F, Merenstein JH. Improving mammography recommendation: A nurse-initiated intervention. J Am Board Fam Pract 1990; 3:87-92.

The above letter was referred to the authors who offer the following reply:

To the Editor: Dr. D'Amico, Dr. Merenstein, and I fully agree with Dr. Hahn's suggestion that all of us, as physicians, extend our concept of mammogram eligibility to include all women whether regular patients, first-time patients, or infrequent patients. This concept would be a noble objective for all screening tests. Unfortunately, strict adherence would still leave large segments of the eligible population unscreened, i.e., those who seek medical care rarely (but often need it more) for whatever reasons. Extending screening to this population is a public health issue of great magnitude.

For our study, using regularly established patients offered the advantage of having past mammography information and more reliable follow-up than had we included first-time or infrequent patients. Because of this, we improved our ability to measure a change because of the intervention. While analysis of the excluded 117 charts would be interesting, the true impact of the intervention could not be measured in this unestablished population because of so many uncertainties. Most importantly, we were unsure whether these patients would be returning and available for follow-up.

Another justification for excluding nonestablished patients is that we wanted to conduct our study in such a way that it was representative of a family practice and the continuity of care, which is at the very foundation of family practice. If family physicians maximize their abilities to offer preventive care, this practice is likely to reap its biggest rewards for patients with established doctor-patient relations.

Edward C. Foley, M.D.
Pittsburgh, PA

Esophagogastroduodenoscopy

To the Editor: It was with great interest and excitement that I read the report of Rodney, et al. about "Esophagogastroduodenoscopy by Family Physicians" (April–June 1990). I differ from these gentlemen in that I was trained in this procedure during residency. My excitement stems from the realization that I am far from alone in our specialty in my performance of EGDs.

My interest is in a notable exception from the list of indications given in Table 2. It seems remarkable to me that in over 700 procedures not one was performed for the work-up of GI bleeding. This has been listed as the primary indication for this procedure.[1,2] My own limited experience would show that when the indication of hematemesis is combined with that of melena, it constitutes the most common reason to perform EGD.

Were the cases done for GI bleeding excluded from the study? Did all the study participants refer these cases to subspecialty care, either due to the increased likelihood that therapeutic intervention would be needed or that they represented more "emergent" situations? Were these symptoms discounted because of their frequent association with those listed?

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