6. Gold RB, Daley D. Public funding of contraceptive, sterilization and abortion services, fiscal year 1990. Fam Plann Perspect 1991; 23:204-11.
7. Jones EF, Forrest JD, Henshaw SK, et al. Unintended pregnancy, contraceptive practice and family planning services in developed countries. Fam Plann Perspect 1988; 20:53-67.
8. US Preventive Services Task Force. Guide to clinical preventive services: an assessment of the effectiveness of 169 interventions: a report of the US Preventive Services Task Force. Chapters 53 and 54. Baltimore: Williams & Wilkins, 1989.

Roles of Family Physicians

To the Editor: While Dr. Scherger is as thought provoking as always, in his article about family practice models (Models of family practice. JABFP 1992; 5:649-53), he errs in assuming that all Kaiser facilities are identical.

Although Northern California Permanente has been slow to appreciate the breadth of family practice training, most of the Southern California Kaiser facilities utilize family physicians in both inpatient and outpatient settings.

At Kaiser Fontana, for example, our family physicians have had full inpatient privileges in medicine, intensive care and cardiac care units, pediatrics, and optional obstetrics for more than 20 years. The majority of the staff at the Fontana medical center practice obstetrics, and in the past year we have expanded privileges to our satellite physicians who wish to practice obstetrics. Our family medicine residents operate three inpatient services with the help of family medicine and internal medicine attending physicians.

In the outpatient setting, the Fontana family medicine department handles all acute surgical and orthopedic trauma cases for the medical center, does its own admissions, and operates subspecialty clinics for colposcopy, vasectomies, minor surgeries, sigmoidoscopies, counseling, and dermatology.

One of the attractions of family medicine training in a Southern California Kaiser facility is the opportunity to learn and use a full range of inpatient, outpatient, and procedural skills from family medicine attending physicians who model these skills in their daily practices.

Irvin S. Roger, MD
Kaiser Permanente
Fontana, CA

To the Editor: In his article, "Models of Family Practice," which appeared in your November-December issue, Dr. Scherger makes several references to Kaiser Permanente and suggests that family physicians in our group model health maintenance organization (HMO) either focus on or are limited to office care. This is simply not true.

Within our Northern California region, we offer family physicians a wide variety of practice settings. At some of our medical centers and clinics, family physicians have chosen to limit their practice to ambulatory care or emergency department services. At other locations, however, we provide more traditional family practice services, including comprehensive outpatient, inpatient, and intensive care unit care, home care, and nursing home visits. In addition, many family physicians within our group regularly provide outpatient pediatric, gynecological, surgical, orthopedic, and trauma care. Family physicians interested in joining our group are encouraged to speak directly with individual family practice department chiefs about the role of family physicians at a particular facility.

Just as one cannot make broad generalizations about the role of the family physician in our society, one cannot accurately make a blanket statement about the role of the family physician within the Permanente Medical Group. I do agree wholeheartedly with Dr. Scherger that making medical students aware of the rich diversity of practice models available to family physicians (within both HMOs and traditional fee-for-service settings) would make them more likely to choose family practice residencies. No other specialty training gives graduating residents such a wide array of exciting and challenging practice opportunities.

John M. Chuck, MD
Kaiser Permanente
Fairfield, CA

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

To the Editor: Generalizing is always very risky, and the letters from Dr. Roger and Dr. Chuck about my essay demonstrate that. I am delighted they have responded to my article pointing out that the Kaiser Fontana facility in Southern California and the Kaiser Fairfield facility in Northern California have an expanded role for the family physician. This information will add to the office-based role for the family physician, which is common in closed-panel health maintenance organizations (HMOs) or multispecialty groups. What Drs. Roger and Chuck and their faculty have done in establishing an expanded role for the family physician in the hospital shows that these roles are not static and can actually move in the direction of greater services for the family physician over time.

Joseph E. Scherger, MD, MPH
Sharp Health Care
San Diego, CA

Limits of Technology

To the Editor: The juxtaposition of the two editorials in the September-October 1992 issue of the *JABFP* created some irony. Does the "Parable of the Big Red Bull"[1] apply to ambulatory blood pressure monitoring (ABPM) discussed on the very next page? This is said to cost "$200 to $300."[2]

For now, let us exclude the "out" one week, then "back in" next week status of the use of diuretics to treat hypertension and such issues as whether we are helping these people or just treating a number. I can treat hypertension in a selected patient with 25 mg/d of generic hydrochlorothiazide for under $10 per year. Yes, this treatment requires periodic laboratory tests. But so do all medications, and we will be following this population regularly for blood pressure and other cardiovascular risk factors anyway. When should we spend the equivalent of the cost of 20 medication years for ABPM? If ABPM is satisfactory, how often should it be repeated (at such cost)?

I agree in the validity of "white coat" hypertension and the need to be reasonably sure of a condition before treating it.[2] Does this mean, though, that we need to prove everything; and how many times, and how often?

As a physician, I am inundated by (often discrepant) articles about new treatments, new drugs, and new tests. What I really need, now, beyond being told to do things "carefully,"[2] are specific guidelines on how to react to a patient. Which patients have "mild hypertension," and who needs ABPM?

George W. Bock, MDCM
Craig, CO

References

1. Stephens GG. Primary medical care: a riddle and a parable. J Am Board Fam Pract 1992; 5:540-1.
2. McBride PE, Lillis D, Hanson PG. A new standard for the diagnosis of mild hypertension? J Am Board Fam Pract 1992; 5:541-3.

Review of Clinical Guidelines

To the Editor: Congratulations for initiating the first of a series of articles on the important issue of guidelines. I agree with your editorial totally. Two articles that I believe have great value in any reference to guidelines have been done by Stephen H. Woolf, MD, and published by *Archives of Internal Medicine*.

It would also be important for this journal to address the issues pertaining to the implementation, use, teaching, and training in major medical procedures that are underway in many programs. Guidelines and protocols relating to the training and use of these procedures will be an important area, particularly as they pertain to the issues of certification, credentialing, and privileges.

Your comments and thoughts will be helpful to the readership.

Jay R. Varma, MD
Augusta, GA

To the Editor: Congratulations and thanks to you and to Al Berg and Julie Moy for the fine start on the clinical guidelines series. This is exactly what is needed at this stage of the development of guidelines: a precise requirement that anything purporting to be a "clinical guideline" reflect careful research, as well as the realities of clinical practice. I, for one, will be looking forward to the next article in this section.

John A. Lincoln, MD
Turks and Caicos Islands
British West Indies

Streptococcal Toxic Shock

To the Editor: In the September-October 1992 issue of *JABFP*, Dr. David Whittiker describes a fatal case of streptococcal toxic shock. (A fatal case of toxic shock associated with streptococcal cellulitis. JABFP 1992; 5:523-6). He goes on to characterize this entity as a menace to previously healthy young adults, which no one would deny. The case described, however, raises an obvious question.

The patient was a 38-year-old woman who had a history of prostitution and intravenous drug abuse, as well as hysterectomy for cervical neoplasia and therapy for a rectal carcinoma. It should be apparent to all that there was a very high probability this patient harbored the human immunodeficiency virus (HIV), yet this possibility was never addressed in the presentation. The patient's HIV status would clearly have some bearing on the clinical course.

Streptococcal sepsis can indeed lead to fulminant and lethal infection in the *un*compromised host. Nonetheless, I am left wondering whether the patient fits into this category.

Geoffrey Wittig, MD
Dansville, NY

The preceding letter was referred to the author of the article in question, who responds as follows:

To the Editor: Dr. Wittig makes a point. This patient's immune status was undoubtedly compromised with prior cancer of two different origins. However, the patient was HIV negative.

David Whittiker, MD
Wichita Falls, TX