daunt or destroy many of those who think they are in control of their lives.

Perhaps using family planning counselors from the same cultural background would increase the successful use of family planning.

I would also suggest training in medical anthropology or reading books, such as those by Robert Coles, which might shed a more sympathetic light on the culture and beliefs of patients.

Nancy K. O'Connor, MD
Ellensburg, PA

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

To the Editor: Dr. O'Connor is completely correct that the causes of "unplanned" pregnancies are complex, multifactoral and culturally based. We did not mean to imply that "unplanned" pregnancies were necessarily "unwanted"; in our practice and in the literature it is shown that many of these are "mistimed" and are often wanted once they occur. Many women do cope and succeed with these unplanned pregnancies; some do not.

Our study was one in a group of research projects planned to help discover ways women can take better control of their lives by assuming control of their reproductive functions. To this end, we explored one issue only — whether family physicians were providing the information about birth control at any opportunity they had so that the women could take control of their reproductive health, if they wanted to do so. Without information, women cannot choose whether to use it.

Obviously the area for further study is immense. Why women seek contraceptive advice, what they expect, what health and cultural beliefs affect these encounters and behaviors, what kind of information they receive, how they use it, and why all are issues that need careful investigation. We attempt to understand the cultural background of our patients in every encounter.

Jo Ann Rosenfeld, MD
Bristol, TN

Examination of Placenta after Twin Delivery

To the Editor: I was taken aback when reading the article about twin vaginal delivery after a previous Cesarean section by John P. Fogarty in the November-December issue (Twin vaginal delivery after a previous Cesarean delivery for twins. J Am Board Fam Pract 1993; 600-3). The item that really caused me to sit up and take notice was the line in the case report about the placenta being sent for pathologic evaluation. Lo and behold, it was determined that the twins were diamniotic-dichorionic! Why the unnecessary expense of sending the placenta? Earlier in the same paragraph, it was made clear that the mother delivered a boy and a girl. Perhaps the placenta was sent for other reasons, but determination of the chorion and amnion are usually reserved for same-sex twins to determine if they are identical. I also think it was terrific that the mother delivered twins vaginally after a Cesarean section. Congratulations on the successful delivery!

Janet Beck Jakupcak, MD
Marseilles, IL

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

To the Editor: I appreciate the concerns of Dr. Jakupcak. In this dynamic time of health care reform, attention to cost is an important issue. In this case, however, the patient did not bear any burden for this pathologic examination of the placenta. The delivery was performed at a busy military hospital with a large family practice residency training program. The placenta was examined as a matter of routine and to be complete in this academic setting. That the infants were of opposite sex might appear to obviate the need for this examination, but monozygotic twins might be discordant for phenotypic sex, and the examination of the placenta serves to identify zygosity more firmly than do later, more inconvenient and expensive tests.[1] I thank Dr. Jakupcak for her congratulations and enthusiasm about this fun and interesting case.

John P. Fogarty, MD
COL, MC

References

1. Cunningham FG, MacDonald PC, Grant NF, Leveno KJ, Gilstrap LC. Multifetal pregnancy. In: William's Obstetrics. 19th ed. Norwalk, CT: Appleton and Lange, 1993:891-918.

Primary Care at a Crossroads

To the Editor: We are writing to share some commentary on the article by you and L. Gary Hart titled "Primary Care at a Crossroads: Progress, Problems, and Future Projections," which appeared in the January-February issue (J Am Board Fam Pract 1994; 7:60-70). Although we enjoyed the article and found it to be quite informative, we felt the need to comment on some important and pertinent problems that were not fully addressed.

By way of background, we are employees of the US Public Health Service in the Denver regional office (PHS Region VIII). We are responsible for oversight of the federal programs designed to provide primary health care services for the medically underserved in our six-state region (CO, MT, ND, SD, UT, and WY), which consists primarily of rural and frontier areas. Ms. Bailey is Director of the Division of Health Services Delivery, which oversees the regional activities of the federal government's Maternal and Child Health Bureau, the Office of Population Affairs (our family planning programs), and the Bureau of Primary Health Care (which includes the National Health Service Corps and the community and migrant health center program, among others). Dr. Babitz is a board-certified family physician who serves as the Regional Clinical Coordinator and Associate Division Director for Clini-

cal Affairs. He also holds clinical faculty appointments with the University of Colorado School of Medicine in the Department of Family Medicine and the Department of Preventive Medicine & Biometrics, where he precepts family medicine residents and teaches community-oriented primary care.

We were concerned by the minimal discussion of the impact of Medicare's GME (graduate medical education) funding formula on the postgraduate training of physicians. This multibillion dollar program has far more impact on the specialty distribution of our nation's physician manpower than the few million dollars (albeit important ones) spent through Title VII. If the federal government were able to overcome the special interest groups desiring to maintain the status quo, two simple changes in this funding stream would have far-reaching effects. First, these funds should be available to *non-hospital-based* residency training programs. By making these funds available only to hospitals, the federal government is severely hampering the development and expansion of primary care training programs having a community base. Second, by changing the funding formula to provide much higher payment rates to primary care residencies than to other programs, the growth of such programs would markedly decrease and perhaps reverse. Our understanding is that minimal changes along this line have been introduced in the Congress, but have not been passed.

We are also concerned with the continual use of the term *specialist* versus *generalist* when describing types of physicians. We are far overdue for a semantic paradigm shift that would provide a meaningful analogy to our colleagues and to the public. In fact, family physicians, general internists, and general pediatricians are as much specialists in their own right as are internal medicine subspecialists or surgical specialists. The reality is that we have two markedly different types of medical specialists practicing in our country. There are generalists, as you have defined them, and then there are *partialists*. The term partialist was not first coined by us, but rather by a prominent family physician leader who preferred not to be credited with this terminology (probably for very good reasons). On the other hand, we have found this term most descriptive and useful in explaining the problems of having an overly specialized (partialized) supply of medical providers. The problems of fragmented, discontinuous, overly technical, curative-focused care are to be expected from a partialist delivery system. Patient-centered, continuous, biopsychosocially oriented, preventive care is to be expected from a generalist delivery system. Primary care providers need to take a bold step with the public and our elected officials in making this semantic shift, which best describes the problems of excessive "specialization."

Our third concern relates to the focus of our health care delivery systems and medical education systems. For the past 9 years the Public Health Service has been promoting the concept of community-oriented primary care along the lines of the Institute of Medicine report from 1984. If our nation is truly to move to a focus of improved health outcomes, then we must understand the concepts of community health needs assessment and targeted programs that address high-priority health needs. Managed care systems have learned those lessons from a financial perspective but could do better in applying them toward improvements in health status. Our nation's medical providers (generalists and partialists) are trained, and then practice, in a "patient demand" system of care. In other words, we see whoever is in the next examination room, regardless of how or why they got there, to the exclusion of problems of greater impact that might be present in our patient (or target) population. This type of system accounts for much of our inability to deliver comprehensive preventive care to our citizens, such as the low immunization rates among our children, even those without financial, geographical, or cultural barriers to care. Until we train our physicians to keep one eye (or foot) in the community and the other in the examination room, we will not maximize our health status. Just training more family physicians who practice a patient demand style of care might be helpful but could result in far less impact on our nation's health status than expected or desired.

Fourth, we were disappointed that the historical review and analysis did not discuss the impact of the community and migrant health center movement, which greatly parallels the family practice movement and the federal government's attempts to improve people's access to health care services. Like the Medicare and Medicaid programs, the community health center movement began in the mid-1960s as part of the efforts of the Office of Economic Opportunity. As an effective mechanism to provide health care services to medically underserved populations, urban and rural (and frontier), this program has steadily grown in size and scope. Some 7 million individuals are provided primary health care services through more than 600 community health centers, migrant health centers, and health care for the homeless projects, along with a number of other special programs (e.g., HIV projects, perinatal projects, public housing health centers). These centers continue to be located in communities that would otherwise be denied access to primary health care services because of a combination of financial, geographic, and cultural barriers. These programs, which generally do practice community-oriented primary care, serve communities that have as great a demand for primary care physicians as any other sector of our society and have been able to maximize the impact of these physicians' services in their communities. Additionally, we are seeing a movement toward basing primary care training programs (especially family medicine residencies) in community health centers. These service-education linkages can, potentially, graduate a much more effective primary care specialist than we have produced in traditional, hospital-based training programs.

Finally, we believe that the article, especially in the conclusions, overly emphasized the "medical" issues in primary care. New partnerships were discussed but not

the role of community-based organizations, local and state health departments, or our fellow primary care providers, i.e., nurse practitioners, physician assistants, and certified nurse midwives. The urgency of our nation's health care crisis demands that we seek inclusive solutions that will utilize all available resources and not fall victim, again, to only "doctor-dominated" solutions.

If we are to improve the health status of our citizens, we must substantially alter the types of physicians being trained, the nature of their training, the systems in which they practice, and the extent to which their services are provided in a collaborative manner.

Thank you for the opportunity to add to the list of important issues that you described in your excellent article. The issues we have shared in this letter are also waiting at the primary care crossroads for a new direction; we hope our nation's leaders will choose the right path.

Barbara E. Bailey
Marc E. Babitz, MD
Denver, CO

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

To the Editor: The thoughtful and constructive commentary by Ms. Bailey and Dr. Babitz is welcomed in response to our article "Primary Care at a Crossroads." From their particular vantage points, they add important further perspectives on this admittedly large subject. Naturally, in an article covering the wide scope of primary care during the last 30 years, it was impossible for us to comment upon all of the issues involved or to deal in depth with many important issues.

We agree with Bailey and Babitz that major changes in funding of graduate medical education in the generalist fields are urgently needed. Fortunately, various initiatives are currently in process at the federal level and in many states in an effort to restructure graduate medical education for the purpose of training an increased number of generalist physicians.

We do not apologize for the use of the term generalist, which in many fields outside health care commands higher prestige and responsibility than more narrowly focused individuals. Whatever terms are used, they should reflect more what each type of physician does in practice. We believe that it is educationally and professionally sound to specialize horizontally across a broad spectrum of clinical content as a generalist. Further, it is crucial to the effectiveness, efficiency, and equity of our health care system for it to be anchored by a coterie of well trained and respected generalists. Vertical specialization in a more narrow field is only one type of specialization. Vertical specialization in a more narrow field is only one type of specialization.

Specialization as a generalist is both professionally challenging and essential to the success of our health care delivery system. While physicians have an important part to play in better integrating community health perspectives into our health care delivery system, the success of this effort is also tied to the restructuring of the delivery system and the activities of health care and community leaders.

We also agree with the important elements of community-oriented primary care and that family physicians need to be trained with appropriate skills and perspectives to contribute to problems of community health. At the same time, the structure of our present health care system tends not to facilitate such an approach and in many instances acts as a barrier to such care.

Bailey and Babitz raise other good points concerning the diversity and common interests of past and present activities in primary care. Their call for increasing dialogue and collaboration among the many groups involved in primary care is appropriate. At the same time, however, our belief is that the well-trained generalist physician, increasingly functioning in group practice and in close collaboration with consultants, other health professionals, hospitals, and other health agencies in the community, should necessarily provide the basic foundation for a restructured health care system.

John P. Geyman, MD
L. Gary Hart, PhD
Seattle, WA

Primary Care at a Crossroads

To the Editor: The article by Geyman and Hart[1] is certainly a timely and elaborate exposition of the chain of events and experiences in the developmental realm of our discipline. In no way will the specialist ever be able to comprehend the needs of society at the grassroots level. Unfortunately the trends of superspecialization by young medical graduates and the technological advances that have occurred in the West had an influence on developing countries, whose physicians have similarly been lured away from generalism to specialization. As a result there has been little interest in the evolution of family medicine in the United States. Because it is hoped that a trend toward generalist medicine will work itself to developing countries with time, the leaders and educators in primary care have a much broader responsibility as the boundaries of our global family erode.

In addition to the various solutions and suggestions that are espoused by Geyman and Hart, we might want to keep in mind that the technology which has evolved during the last decades will continue to develop with even greater momentum. As this occurs, we need to ensure that wherever possible newer subspecialities should not be allowed to sprout.[2] Instead, we feel it would be in the interests of the society as a whole to make this new knowledge and technology available at the primary care level by training family physicians in a continuous process, as has occurred with other procedures and technology.[3] Such an approach would also help prevent the turf wars that seem to occur periodically.