Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints might prevent this in some cases. The problem is compounded in the case of a bimonthly journal where continuity of comment and redress is difficult to achieve. When the redress appears 2 months after the comment, 4 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.

Health Care Reform

To the Editor: I was extremely disappointed by Howard Brody's incomplete summary of the report from the Clinton Health Care Reform Task Force (*JABFP* 1994; 7:236-41). Nowhere does Dr. Brody mention that the report is 1342 ***pages*** long. This simple fact guarantees that the plan will be a failure from the start. Just think of the funds wasted on duplicating charges alone. The Declaration of Independence, in comparison, contains 1,322 ***words***! Nor does Dr. Brody mention that this bloated manifesto contains the word "mandatory" 24 times, "penalty" 59 times, "prohibit" 51 times, "obligation" 56 times, "restrict" 54 times and "limit" 269 times. Obviously, the plan's writers believe coercion is necessary. Neither does Dr. Brody mention the hidden implications of the plan: vastly higher taxes on everything, massive bureaucracy, identification papers (health security cards), lack of patient confidentiality (medical records accessible by the government), fines, imprisonments, forfeitures of property (especially of physicians), and government control over who can purchase what medical care. These are all the hallmarks of a totalitarian state. In fact, the Clinton plan and those like it are a huge federal power grab over the lives and welfare of all citizens comparable with the takeover of Germany by Hitler. And remember, Hitler was ***voted*** into power.

There is indeed a health care crisis in this country, namely, most persons have too much health care and a very few have too little. At least 50 percent of the patients I see at my clinic do not need to be seen at all. During a 2-hour period last week, I saw 2 patients with paper cuts, 4 with sniffles, and 2 with mosquito bites.

The solution: adopt medical savings accounts along with tort reform to eliminate bureaucratic bloat and waste. Physicians would once again treat the poor as charity cases as my family physician did for me when I was a little girl.

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

To the Editor: Dr. Bett's position on health reform appears to equate any mandatory Federal role with a tyranny equal to Nazi Germany's. This view ignores the interference with the physician-patient relationship and with good medical practice that can arise to an even greater extent within the "free" marketplace.

An excellent rebuttal to Dr. Bett's view is provided by Berenson.[1] Berenson assumes that managed competition, as envisioned in the Clinton plan, is in the public's interest; he then asks whether it is also in the physicians' interest. He concludes that if physicians knew their own best interests, they would endorse the Clinton plan or something very close to it; or, as an alternative, they would endorse a Canadian-style single-payer system (recently endorsed by the American College of Surgeons). Unfortunately, physicians are so used to opposing "government interference" as a matter of habit that they fail to realize that the real dangers to high-quality, personalized medical care currently arise from a different direction.

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References

1. Berenson RA. Do physicians recognize their own best interests? Health Aff 1994; 13 (Spring II) 185-92.

Consultation and Referral

To the Editor: The article by Williams and Peet in the recent issue of the *JABFP*[1] and an editorial by Geyman[2] in the same issue reminded me of other published articles and studies on the subject of consultation and referral. It remains a germane and largely unresolved issue in this time of "reform."

Earlier writings certainly admonished us to establish more collaborative relationships among physicians in the care of patients.[3,4] One of our studies confirmed that the ambulatory referral pattern in a family practice residency program does relate to the real life of practice and can relate residency education to future practice expectancies and needs.[5] A generation of residency-trained family physicians is now in practice and utilizes consultations and referrals on a regular basis. While in some cases this referring family physician remains a member of the team, more often the consultation becomes a functional referral, and the patient ends up without continuous or comprehensive care, with more fragmentation occurring as each new subspecialist is added.[6]

Other studies have shown that family physicians more commonly consult with or refer to subspecialists than to generalist specialists, the primary reason being the need for a consultant with a particular technical (procedural) skill.[7]

Consultation with and referral to family physicians by other family physicians, other generalist specialists, and limited subspecialists has also been documented.[8] Fragmented tertiary care lends itself well to integra-

tion of the broad-based family physician as an appropriate consultant, and patients will benefit as these physician collaborations become more formalized and frequent.

As the reference article[1] and editorial comment[2] conclude, the consultation-referral issue remains unresolved. The resolution seems at least twofold: education and practice based. Must we wait longer?

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References

1. Williams PF, Peet G. Differences in values of clinical information: referring physicians versus consulting specialists. J Am Board Fam Pract 1994; 7:292-302.
2. Geyman JP. Communication problems and needs in the consultation and referral process. J Am Board Fam Pract 1994; 7:357-8.
3. Fry J. Hospital referrals: must they go up? Changing patterns over 20 years. Lancet 1971; 2:148.
4. Stephens GG. Consultant, referral, or collaboration? Continuing Educ Fam Physician 1978; 9:17-8.
5. Dolezal JM, Amundson LH, Sinning NJ, et al. Pricare and ambulatory referral. Continuing Educ Fam Physician 1980; 12:84-94.
6. Amundson LH. The family physician as consultant. Continuing Educ Fam Phys 1986; 21:111.
7. Vogt HB, Amundson LH. Family physician consultation/referral patterns. J Am Board Fam Pract 1988; 1:106-11.
8. Amundson LH, Vogt HB. The consultant family physician. J Am Board Fam Pract 1989; 2:34-6.

Full-Term Abdominal Pregnancy

To the Editor: Dr. Old's[1] recent report on successful outcome in a case of abdominal pregnancy (*JABFP* 1994; 7:342-3) brought to mind a previously unreported case that might be of interest to readers even though the details have been lost. In 1958 or 1959 a Native American (Lakota) woman presented at the Pine Ridge Indian Hospital in South Dakota at term in apparent labor. Fetal movement and heart tones were easily detected. The examining physician was easily able to palpate a fetal foot through the anterior vaginal wall in the area between the pubic symphysis and the cervix. Reasoning that this could only occur with uterine rupture or an abdominal pregnancy, and finding the patient's vital signs and appearance quite normal, he arranged for immediate ambulance transfer to the care of an obstetrician 120 miles away in Rapid City, SD. The consultant subsequently reported that the diagnosis of abdominal pregnancy was correct, that surgery was successful with (if memory serves correctly) 7 units of blood transfused, and that mother and baby both survived in good condition. If there is a lesson to be learned from this case, it is that careful clinical examination can sometimes lead to a correct and timely diagnosis in this rare condition.

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References

1. Old JL. Full-term abdominal pregnancy: mother and infant survival. J Am Board Fam Pract 1994; 7:342-3.