The philosophy of our family practice residency program is that good family physicians use their hands. Learners are taught to be comfortable touching patients' bodies and to pay attention to doing the little things for patients that add to the intimacy of the visit. We also try to provide opportunities to acquire skills in the bigger procedures — colposcopy, sigmoidoscopy — but that is of secondary importance. We teach our learners to use their hands because it makes them better physicians.

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Obstetrics in Family Practice

To the Editor: I am writing in response to the article by Walter L. Larimore and James L. Reynolds regarding family practice maternity care in America.[1] As a family physician who both practices and teaches family-centered maternity care, I appreciate the authors' summary of the recent medical literature regarding this topic. I agree strongly with their conclusions that family physicians have an important place in providing maternity care, which we need to emphasize further in our residency and fellowship programs.

I further agree emphatically that even as we strive to train ourselves technically, we need also to learn from our colleagues in midwifery regarding more "low-tech, high-touch" care, so that we do not become merely mini-obstetricians. I have some thoughts regarding jumping on the midwifery bandwagon, however. First of all, it is my sense that by definition nurse midwives come to their practice from a very different paradigm of care for the patient, with much more emphasis on hands-on, moment-to-moment comforting measures than physicians get in their medical training (where, for example, changing soiled linens or stroking a patient's forehead with cool cloths is not considered "the doctor's job"). As we seek to understand and incorporate such labor support into our routines of intrapartum care, in hopes of lowering operative intervention rates, we need to be able to redefine or reallocate these traditional roles.

Second, as Drs. Larimore and Reynolds mention, another big difference in training for midwives versus family physicians is that most midwives "have no previous knowledge of the woman or her family and do not provide ongoing care to the newborn child."[p. 481] I think this difference is critical and must be emphasized strongly in terms of what family physicians can do differently in caring for women and their families. This cross-generational longitudinality of care is the crux of family medicine and is what makes our potential for family-centered maternity care so unique, what makes us not only more than mini-obstetricians but also more than mini-midwives. In my professional and personal experience with midwives, even those most attuned to labor support issues miss opportunities for a true family orientation to perinatal care; e.g., by not addressing the father's or grandmother's concerns or interests at a prenatal visit. A family physician's training in taking genograms could in a prenatal interview elicit valuable psychosocial information regarding both parents' families experiences with pregnancy and childbirth.

Thus I think while we have much to learn from midwives regarding labor support and "low-tech" perinatal care, we also have much to teach them (and our obstetrician colleagues) about truly family-centered care.

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To the Editor: Congratulations and thanks to the *Journal* for publishing the article by Larimore and Reynolds[1] and the accompanying editorial by Borst[2] dealing with obstetrics in family practice. These writings should be required reading for medical students on their family practice clerkships, family practice residents, and also for our own faculty as a source of balance or reinforcement against the learned helplessness that still unfortunately pervades the medical education system. Although many of the points made in the article are "givens" to those family physicians who include perinatal care in their practices, this collection of historical perspective and point-by-point discussion of the issues of obstetrics within family practice, presented in an upbeat style, is just what is needed to balance the negative recruitment our trainees face in academic centers.

Hidden in the article and implicit in the historical perspective of the editorial is an important issue that deserves much more attention by researchers: How does family physician participation or nonparticipation in perinatal care contribute to maternal-child health or morbidity? A recent study of this issue by Larimore and Davis[3] should spur others to look at their particular practices and geographical areas for answers. Perhaps further study will show that well-trained family physicians can succeed where regionalization of perinatal care according to the subspecialty model has failed to reduce perinatal mortality and morbidity in many geographical areas. Favorable data would provide needed chips for the academic center games our trainees must play and ammunition for the hospital privilege battles that our graduates face.

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