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 a bimonthly journal where continuity of comment and redress are 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.

Perinatal Outcomes and Family Practice

To the Editor: I found the article by Deutchman et al[1] of interest, and as a family physician who delivers babies, I was encouraged by their findings. There were, however, two limitations of the study which concern me. The first is the decision to lump all forms of diabetes and all forms of hypertension together. While I understand the limitations in their data-gathering method, one cannot escape the possibility that family physicians and obstetricians were taking care of different populations, perhaps with the more seriously ill patients in these categories cared for by obstetricians.

Second is the major differences in insurance reported for the two specialists' patients. One wonders whether the 81 percent Medicaid-insured patients of the family physicians compared with the 14 percent Medicaid-insured patients of the obstetricians could have had different care on that basis alone. Studies have shown that privately insured women consistently have higher Cesarean section rates than do Medicaid patients.[2,3] In one study the private-paying patients had a rate of 29.1 percent, those insured by non-Kaiser health maintenance organizations 26.8 percent, Medi-Cal 22.9 percent, Kaiser 19.7 percent, self-paying 19.3 percent, and indigent patients 15.6 percent.[3]

My point here is not to argue that these differences do explain or confound the findings of this study. It is, however, to raise them as serious concerns. They make the data difficult to interpret at face value. I wonder whether the authors have looked at controlling for payment source, and whether after so doing, they would have enough statistical power to draw conclusions.

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References

1. Deutchman ME, Sills D, Connor PD. Perinatal outcomes: a comparison between family physicians and obstetricians. J Am Board Fam Pract 1995;8:440–7.
2. Stafford RS. Cesarean section use and source of payment: an analysis of California hospital discharge abstracts. Am J Public Health 1990;80:313–5.
3. Stafford RS, Sullivan SD, Gardner LB. Trends in Cesarean section use in California, 1983 to 1990. Am J Obstet Gynecol 1993;168:1297–302.

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

To the Editor: Dr. Krall raises two important issues in his comments about our study. The first is the fact that because all types of diabetes and hypertension were combined in our risk-scoring system, a significant difference in the family practice and obstetrician patient populations could have been missed. If such a difference exists and if that difference shows the patient population cared for by the obstetrician group to be the higher-risk group, some of the observed excess in the Cesarean section rate among the obstetricians' patients could be accounted for. To address that concern, we have reanalyzed our data, excluding all cases of diabetes and hypertension. Any changes that resulted in Tables 3 and 4 are presented below. The large and significant difference in diagnosis of cephalopelvic disproportion and Cesarean section rates persists after this adjustment just as it did for the other permutations discussed in detail in the original study. The overall risk scores for the two groups still showed no statistically significant difference ($P = 0.75$) after the adjustment. Physician specialty seems to be the only way to account for the differing Cesarean section rates.

Upon performing this reanalysis, it was interesting for us to note that adjusting out cases of diabetes and hypertension caused the reduction of 37 patients (6.4 percent of total) from the family physician patient population and 47 patients (3.4 percent of total) from the obstetrician patient population. This difference is statistically significant at the $P = 0.007$ level.

Thus, even though the original analysis did not show a significant difference between the two groups when risk factors were compared individually, combining the two risk factors of hypertension and diabetes suggests that the family physicians' population was a higher-risk group. Many other studies have also shown that family physicians end up taking care of high-risk pregnant women.

The second issue raised is the difference in insurance coverage between the family practice and obstetric patient populations (family physician patients were 81 percent Medicaid versus 14 percent for obstetricians). The effect of insurance type on physician behavior is an issue that bears further study. Regardless of the insurance differences in our study, the fact remains that perinatal care provided by this group of family physicians produced maternal and infant outcomes similar to those produced by obstetricians, simultaneously affording the mothers a significantly greater chance of vaginal delivery. These equivalent outcomes

Revised Table 3 After Removal of All Diabetic and Hypertensive Patients.

Complications	FP Patients (n = 541) No. (%)	OB Patients (n = 1317) No. (%)	*P* Value
Abruptio placentae	4 (0.7)	8 (0.6)	NS
Placenta previa	2 (0.4)	4 (0.3)	NS
Precipitous labor	6 (1.1)	7 (0.5)	NS
Breech	12 (2.2)	37 (2.8)	NS
Cephalopelvic disproportion	20 (3.7)	115 (8.7)	0.007
Other complications	21 (3.9)	65 (4.9)	NS

FP - family physician, OB - obstetrician

Revised Table 4 After Removal of All Diabetic and Hypertensive Patients

Outcomes	FP Patients (n = 541) No. (%)	OB Patients (n = 1317) No. (%)	*P* Value
Gestational age <37 weeks	26 (4.8)	73 (5.5)	NS
Forceps	7 (1.3)	58 (4.4)	0.001
Vacuum extractor	12 (2.2)	5 (0.4)	0.001
Cesarean section, repeat	13 (2.4)	108 (8.2)	<0.001
Cesarean section, primary	74 (13.7)	252 (19.1)	0.017
Unassisted vaginal delivery	411 (76.0)	878 (66.7)	0.052

FP - family physician, OB - obstetrician

with a lower Cesarean section rate occurred in an environment dominated by obstetricians and their practice style. It is our conclusion that the relative autonomy enjoyed by the family physicians in this study is an important factor in producing the lower Cesarean section rate.

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Family Medicine in Massachusetts

To the Editor: I enjoyed the article by Dr. Eckhert in the November-December 1995 issue of the *JABFP* about the progress of family practice training in Massachusetts (Eckhert NL. Family medicine in Massachusetts: coming of age at last. J Am Board Fam Pract 1995; 8:475-80.) I completed my combined residency in family practice and pediatrics at the Harvard Family Health Program in 1973. One omission of the Eckhart article was a description of the Harvard Family Health Program based at Boston Children's Hospital. This residency program began 1 July 1969, prior to the residency at the University of Massachusetts, and was one of the first programs in the country. The residency was sponsored jointly by the Boston Children's Hospital and Peter Bent Brigham Hospital. The training allowed the trainee to become board-eligible in both family practice and pediatrics or internal medicine in 4 years.

At that time there was good support from the chiefs of staff of the two participating hospitals, Boston Children's and the Peter Bent Brigham (now Brigham and Women's Hospital). The program itself had good leadership from Drs. Robert Haggerty, Joel Alpert, and Richard Feinbloom (all were pediatricians), who believed in the concepts of family medicine. Ultimately, however, the retirement or loss of these key leaders and the supportive chiefs of the participating hospitals led eventually to the demise of the program in July 1974.

It currently does not appear that Harvard Medical School has the needed leadership to establish a family practice department or even a division in this era of increased demands for our specialty. It would be nice to see someone step forward to assume this leadership.

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Use of Mammography

To the Editor: I enjoyed Dr. Foley and colleagues' recent article on a nurse-initiated intervention to improve mammography recommendations.[1] Despite their recognized inability to separate their progress from the secular trend, they at least are dealing with a positive improvement. Secular trends in mammography use have been remarkable. In a recent article Breen and colleagues[2] reported a doubling between 1987 and 1990 of the proportion of women aged 40 years and older who had a recent mammogram. Experience during the early 1990s in our staff model health maintenance organization (HMO) was that 56 percent of women aged 50 to 65 years had a mammogram in the previous 2 years.[3]

As does Dr. Foley's work, our HMO experience relies upon a fundamental change in the way we organize the care system.[3] We use a computer-generated reminder directly mailed to women. More tests of delivery system changes need to be done using controlled designs. Changes within our system and supports, more than new knowledge and better guidelines, translate what we know into what we do.[4]

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