

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. Eckhart in the November-December 1995 issue of the *JABFP* about the progress of family practice training in Massachusetts (Eckhart 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 fam-

ily 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 colleagues² 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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