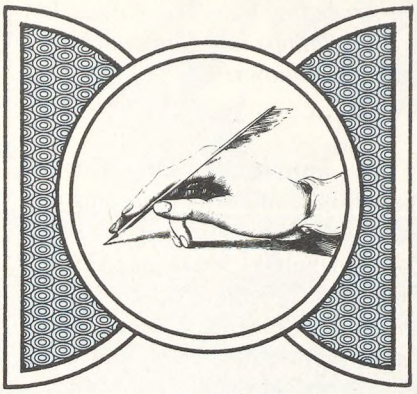
Letters to the Editor



The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Outcome of Obstetric Care in Family Practice

To the Editor:

I was interested to read the paper by Drs. Phillips, Rice, and Layton on the comparison of obstetrical case outcomes between general practitioners, family medicine residents, and private obstetricians *(Audit of Obstetrical Care and Outcome in Family Medicine, Obstetrics, and General Practice. J Fam Pract 6:1209, 1978).* The conclusions of the study, that the care provided by family medicine residents compares favorably with the others, may be modified by some variables that the authors might well consider.

First, there arises the question of the random selection of 50 patients from each group's patient population. How was this randomization undertaken and were these 50 cases representative of all the patients and the work carried out by each group of physicians? This certainly does not represent an equal sampling of the total patient populations, since the sample of family medicine residents' total cases was 63 percent; of private obstetricians' patients, 12 percent; and of the general practitioners, 57 percent. One cannot therefore conclude that the 50 selected cases from each group reflected the characteristics of that group, nor can one make comparisons of the three groups and extrapolate the conclusions to the general performance of family medicine residents.

Secondly, it would be useful to know whether the supervision of residents at each delivery by family medicine faculty and private general practitioners played a significant role in decision making in the care of their obstetric patients. If this was indeed so, conclusions regarding the performance of the family medicine resident group should include comments regarding not only residents but also faculty members and private general practitioners. Did the latter physicians also form part of one of the other two groups studied, the private general practitioners? If so, this tends to cloud the comparisons undertaken.

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Thirdly, the implied conclusion that the Family Medicine Group undertook fewer interventions and anesthesia, thus ensuring a more "natural" childbirth may well be a valid one, but could also be explained either by a reluctance (for whatever reason) to resort to forceps extractions, or the type of birth preparation to which the women were exposed in the prenatal period. It has been reported that Lamaze training leads to less frequent narcotic therapy, less conduction anesthesia, and a higher rate of spontaneous vaginal deliveries.[1]

Unfortunately, the study of childbirth is filled with a host of interrelated variables, some accurately measurable, others attitudinal and social in nature. Consequently investigations in this field are notoriously difficult to undertake. This present study, which is a good start to establishing the effectiveness of family medicine in providing obstetric care might well be developed into a prospective randomized controlled trial in order to further validate the conclusions reached by Dr. Phillips and his co-workers.

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Reference

1. Scott JR, Rose NB: Effect of psychoprophylaxis (Lamaze preparation) on labor and delivery in primiparas. N Engl J Med 294:1205, 1976

The preceding letter was forwarded to Drs. Phillips and Layton who respond as follows:

We appreciate Dr. Curtis' thoughtful comments regarding our study, "Obstetrical Care and Outcome in Family Medicine, Obstetrics, and General Practice" *(Phillips WR, Rice GA, Layton RH: J Fam Pract 6:1209, 1978)*, and share his interest in further study of the role of family medicine in obstetric care.

To answer Dr. Curtis's first question, our random patient selection process consisted of retrospectively taking the total number of patients in each of the three groups for the year studied and randomly selecting 50 patients from each. We thereby attempted to avoid the introduction of bias in patient selection attributable to time of year, previous duration of resident training, and other factors. Although it is true that the equal 50-patient samples do not represent equal proportions of their respective populations, they constitute random and representative samples. Insofar as observed differences meet statistical tests of significance, valid conclusions can be made about the likelihood that the differences observed between the samples represent actual differences between the populations. Of course, extrapolations to populations other than those studied must be made with caution.

The second point regarding supervision of resident deliveries by family medicine faculty and private general practitioners is an in-

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teresting one which we considered in our study but did not report due to lack of information. Both groups attended resident deliveries and the private general practitioner attendings were indeed a subgroup of the private general practitioner group studied separately. The significance of their role in patient management decision making is difficult to assess, but we feel that in general residents make decisions and manage their obstetrical patients independently with the attending serving as back-up for discussion, teaching, and emergencies. Certainly the common effect these private general practitioners may have had on both the family medicine and the general practice groups may cloud the comparisons made. Such a common effect, however, would serve only to decrease any observed differences between the two groups, representing larger true differences between the populations. Thus, the conclusions based on significant observed differences are valid despite the cross-over effect, although we may have failed to observe more minor differences where they may actually exist between the populations.

Dr. Curtis's third point accurately describes our feeling that the decreased degree of obstetrical intervention in the family medicine group compared to the obstetrics and general practice groups is due primarily to a difference in style and philosophy of practice and patient education.

We agree that our study represents only a starting point in the investigation of the effectiveness of family physicians in obstetric care. Further studies exploring this important area of family health care are underway within the University of Washington Affiliated Family Practice Residency Network. We expect future studies will both confirm and contradict some of our findings as they document the nature of obstetrical care delivered in other family medicine programs and in other practice settings.

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Research in Family Practice

To the Editor:

After reviewing the papers on "Research in Family Practice" *(J Fam Pract 7:49, 1978)*, I was taken by both a feeling of excitement for the future and concern about the present. In view of the discussion on attitudes for change, it has been my experience that some of our colleagues in the established medical disciplines are not only inflexible but are easily threatened by the search for better ways to approach or manage clinical problems.

One can only guess why many of our bastions of education foster such provincial attitudes. Hopefully, future research will be able to develop in a risk-free, fluid, open-ended, and self-critical atmosphere which will promote true growth, a big job for one specialty.

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