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# International Perspectives

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## Rural Physicians in the German Democratic Republic

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The German Democratic Republic (GDR) is a socialist country that has had a strong commitment, since the Second World War, to provide effective and efficient health care to all segments of the population.

Rural primary health care in the GDR addresses the main health problems in the community, providing appropriate promotive, preventive, curative, and rehabilitative services. The factors which relate to these services are: integration with the national health service, health needs of the rural population, coordination with other aspects of government and society, and the training and distribution of health care workers.

### Integration of Primary Health Care into the National Health Service

In the German Democratic Republic, rural primary health care is fully integrated with the national health care system.

The entire rural population, including those employed in agriculture, are covered by insurance schemes and are entitled to free medical care.

Urban health care establishments, such as district hospitals and district polyclinics, render organizational assistance to typical rural health care establishments such as rural outpatient clinics ("Landambulatorien"), state supported practices, and community nurse stations.

As a rule, district hospitals and district polyclinics in the GDR care for 50,000 to 150,000 people, while rural outpatient clinics and state medical practices cover 7,000 to 14,000 and 2,000 to 5,000 people, respectively.

Although they are the smallest units of rural health care, community nurse stations are of particular importance for the population. On the average, they care for 800 to 1,500 people. Two or three such stations report to a district physician employed in the state medical practice or rural outpatient clinic.

A particularly successful approach in the rural areas has been for every specialist in general practice to take over responsibility for a particular geographical area, without infringing on people's rights and while still permitting them to select the physician they can trust. Ideally, the geographical area of medical care will be identical with the rural community. Of the total number of physicians involved directly in medical care facilities, 56 percent are at present engaged in ambulatory medical services, as opposed to 40 percent in 1956. The majority of them (37 percent) are general practitioners, and at present there is one general practitioner for every 2,230 persons. They practice in three different settings: (1) state supported solo practices; (2) state supported group practices like rural health centers; and (3) private solo practices—these are steadily decreasing because no new private practices can now be established in the GDR.

### Primary Health Care and Actual Needs

In the rural areas, acute morbidity is associated with colds and trivial accidents, while cardiovas-

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cular diseases and diseases of the locomotor system (the latter being especially common in agricultural workers) are very important causes of chronic morbidity. Due to the increased number of elderly people in many rural communities, the proportion of geriatric problems has increased considerably. On the average, the rural general practitioner spends more than 40 percent of his time dealing with geriatric disorders.<sup>1</sup> Since the elderly often have several chronic diseases, complex health care assumes increasing importance. Adams, Knabe, and Knoblauch as well as other authors have shown that 80 percent of problems in primary health care are managed by general practitioners and their teams in the rural areas.<sup>2</sup> Studies of health behavior have shown rural populations to be very appreciative of receiving continuing care from the physician and community nurses of their own choice.<sup>3</sup>

### **Primary Health Services as a Task of Society**

According to the constitution and legislation of the German Democratic Republic, managers of agricultural enterprises, mayors, and local governments are fully responsible for health developments in their respective areas of competence. In living up to this responsibility, they rely on the expertise and practice advice of the local physician and his team. This is also true of local deputies and their standing commissions.

There can be no doubt that school teachers are important allies of the physician in rural health promotion. Good results have been obtained at the Ernst-Moritz-Arndt-University, Greifswald, in preparing both medical students and student school teachers for their future cooperation in the community. This has been achieved through the development of multidisciplinary courses and reports on the living conditions and health status of rural populations.<sup>4</sup>

### **The Training of Rural Physicians**

It was essential to prepare adequately trained physicians and medium level medical personnel

for rural health care work and to interest them in staying in the rural areas. This was encouraged by setting up a new physician cadre, the specialist in general practice, using a four-year residency program after the usual six years of medical school. In addition, regularly scheduled continuing education courses for general practitioners involved in rural health care were developed. These specialists in general practice now are highly regarded among the population at large, and by the medical profession and medical students.<sup>5</sup> Their specialized training takes place not only in hospitals, but also in rural outpatient establishments. The tutors, experienced specialists in general practice, take care of all stages of that training, including assignments to specialized clinical departments of district hospitals, different outpatient establishments, dispensaries, and hygiene inspectorates. In 1965, a total of 45 exemplary rural health care establishments, most of them rural outpatient clinics, became involved in medical education for the first time ever.<sup>6</sup>

Generally speaking, the reform of medical education in the German Democratic Republic has resulted in a stronger emphasis on practical training.<sup>7</sup> Practical courses and internship (one year) appear to be suitable ways of preparing medical students for primary health care functions, the internship ideally being located in a minor hospital or an outpatient establishment. During their internship, these students are trained, mostly in elementary diagnostic methods, making special use of manual skills.

The rural physician is also encouraged to undergo further postgraduate training in order to give proper guidance to the team and assume important functions in the basic and continuing education of medium level medical personnel and voluntary health workers. The physician's role as a team leader is of particular significance in rural areas with a shortage of physicians in primary health care.

### **Summary**

Primary health care is defined by the World Health Organization as a practical approach to making essential health care universally accessible to individuals and families in the community in an

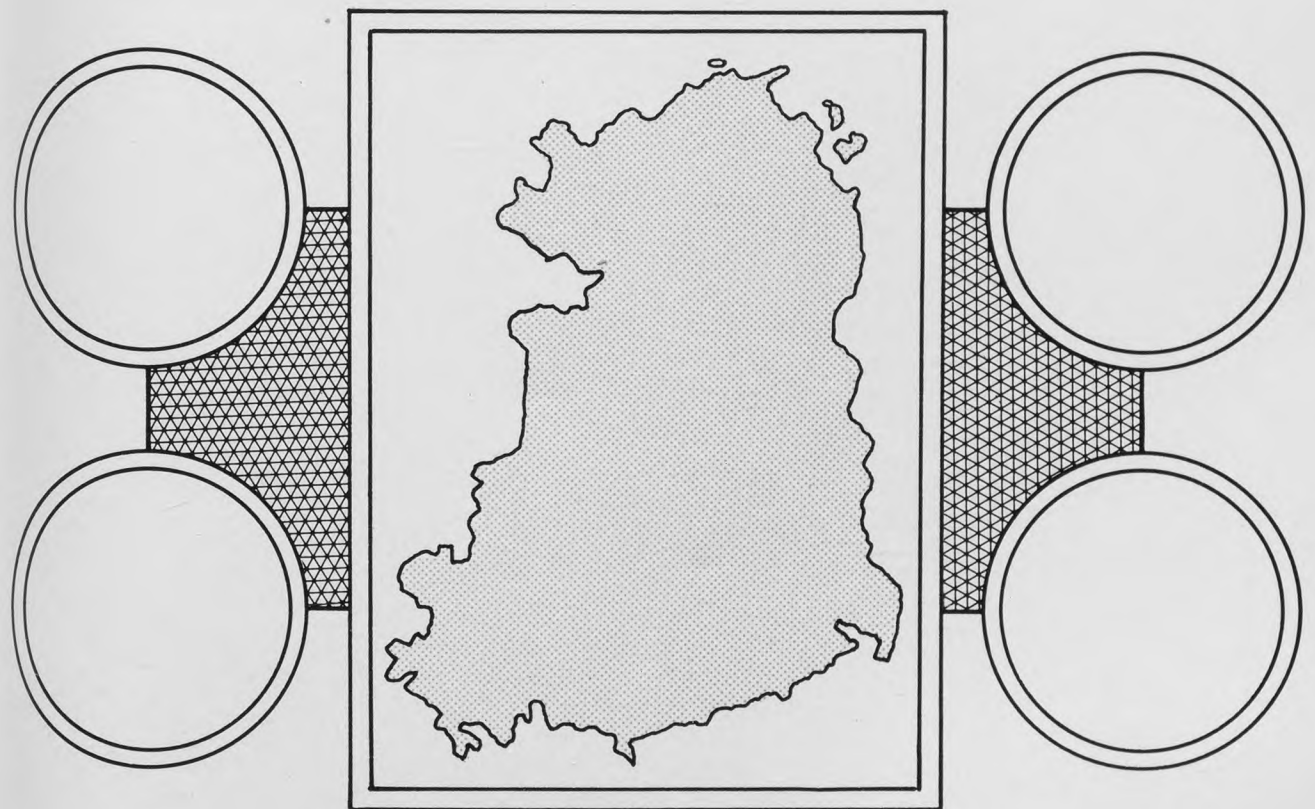
acceptable and affordable way and with their full participation. The above mentioned principles are found to have been largely implemented in the GDR. The decisive prerequisite for this achievement has been full integration of rural primary health care into the national health care system on the basis of the unity of economic and social policies, health care policy being part and parcel of social policy.

An especially successful approach has been for the general practitioner, who in the GDR is a specialist in general medicine, and his health care team (in particular, the community nurse), not to confine their work to curative aspects, but to see to it that prevention and after-care are adequately incorporated into primary health care, taking into account local conditions. In this sense, the specialist in general practice and the community nurse are coordinators and organizers in their area. In the future, medical education and postgraduate training will have to ensure a balance between self-reliance on the part of the specialist in general practice and his team in providing outpatient care to rural populations, and their collaboration with

specialists in the different medical disciplines employed in outpatient clinics and hospitals. While the specialist in general practice should never be a mere referral agent, he should use vertical referral in order to make the achievements of modern medicine and of specialized medical care available to the rural population.

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SOURCE	PROGRAM	MEDIA		AUDIENCE	COMMENTS	OVERALL APPRAISAL
<p>National Audiovisual Center General Services Administration Order Section Washington, DC 20409</p> <p>Purchase: \$66</p>	<p><b>Decision Making and Management Process in Family Practice</b></p>	VT	FP FR		<p>This videotape was produced jointly by the Department of Biomedical Communications at the University of Cincinnati and the Office of Audiovisual Services of the Medical College of Ohio at Toledo. The process and content of a medical interview of a patient with low back pain is presented and analyzed. The process of clinical decision making is illustrated, but psychosocial factors are somewhat neglected and a sexual history is not taken. This program represents an effective use of the videotape format, and may be useful in stimulating discussion concerning the process of clinical decision making.</p>	Of Some Value
<p>Learning Resources Center SB-56 University of Washington Seattle, WA 98195</p> <p>Purchase: \$75 Preview: \$7.50</p>	<p><b>Lumbar Puncture</b></p>	VT	FR MS		<p>This videotape presents the indications and contraindications of lumbar puncture, followed by a well-illustrated description of the technique of this procedure. The videotape is of good technical quality. The procedure is effectively shown in an actual patient. This program would be of particular value in predoctoral teaching programs.</p>	Recommended
<p>Merrell Film Library 1269 Gest Street Cincinnati, OH 45203</p> <p>Free on loan</p>	<p><b>The Best of Care</b></p>	FM	FP FR FA MS		<p>This 30 minute 16 mm film was made through the cooperation of the American Medical Association and the American Hospital Association on the subject of potential legal liability of the hospital and the physician. Case vignettes are shown involving patient identification, in-hospital accidents, verbal and written communication, and foreign body control. The film is of excellent technical quality, and clearly illustrates important medicolegal principles.</p>	Highly Recommended

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satisfaction, relationship with peers and supervisors at present and in the past. Patient's assessment of financial condition, eg, adequacy of income in relation to needs, indebtedness, is also noted. Does work history suggest that the patient tends to move upward when he changes jobs, or that he shifts from one job to another because of difficulties at work? Has he persisted in his present work situation because he likes his work or because it offers him security or both? Is the patient approaching retirement? If so, what are his feelings about it?

### 9. Recent Psychosexual History

This includes the patient's sexual preferences; the quality or degree of satisfaction in the sexual relationship with spouse; problems in functioning, such as decline of sexual interest, impotence, premature ejaculation, retarded ejaculation, anorgasmia, and dyspareunia; concern about homosexual feelings or behavior; and history of sexual affairs by patient or spouse. Obtaining the sexual history requires tact and a sense of timing. The physician may elect to postpone detailed sexual history until later interviews, to restrict his initial inquiry to fairly general questions, or to wait until the patient provides an opening to this subject.

### 10. Personality, Life-Style, Interests

The interviewer attempts to get a picture of the patient's general style of life, including his involvement with friends, clubs, and hobbies. If married, does spouse participate in patient's social life or do they tend to go their separate

ways? Does patient feel lonely, excluded by others, or that he has difficulty in forming stable friendships? How does the patient imagine that his friends would describe him? Has the patient observed any recent change in his social activities and interests?

Does past history of patient's behavior suggest how well the patient tolerates stress or frustration? Has patient successfully pursued long-term goals? Has he tended to be sociable, seclusive, outgoing, secretive, realistically trusting, naive, suspicious, easily discouraged, tenacious, generous, stingy, disorganized, perfectionistic, steady, intellectual, excitable, emotional, impulsive, etc?

### 11. Developmental History

*A. Preschool Years.* To the patient's knowledge, was his mother's pregnancy with him and delivery of him free of complications? Quality and stability of family life during infancy and early childhood. How does the patient describe his parents, siblings, and his relationships with them during this and later periods of his life? Ages at which patient learned to walk and say sentences, if known. History of nightmares, eating problems, enuresis, encopresis, or any other serious behavior problem.

*B. Early School Years.* Patient's recollection of his experiences and feelings when he began kindergarten and the first grade. Is there evidence of unusual separation anxiety? Is there a history of school phobia? Did he play much outside the home? Spend nights at friends' homes? Go to camp? Did patient have chums and did he develop hobbies during grade school years? How did he get along with classmates and teachers? What were his

average grades? Did he have favorite subjects? Did he pass all grades and subjects in this and later periods of school? Is there a history of specific academic difficulties such as learning to read? Is there evidence of the patient's having been exceptionally active, restless, distractable?

*C. Puberty and Adolescence.* Does patient recall first menstrual periods, acquisition of axillary and pubic hair, breast development, voice change, heightening of sexual feelings, early sexual interests in other boys or girls? If so, were these experiences relatively comfortable or pleasurable ones or were they associated with feelings of embarrassment, inadequacy, anxiety, or guilt? What is the person's experience with masturbation and associated attitudes and feelings? In obtaining the sexual developmental history, the physician exercises the same tact and precautions about timing as he does in obtaining the recent sexual history.

History of dating behavior, crushes, important relationships with peers of both sexes, interest in intellectual pursuits, sports, part-time jobs. Was patient's adolescence relatively quiet or was it quite turbulent? Did he seem to make a successful shift of interests and emotional involvements to people and activities outside the home or did he remain dependent on his parents? Did he become involved in a continuing struggle with parents? Did he come into serious conflict with authorities?

*D. Young Adulthood.* Did patient achieve a sense of knowing what he wanted to do in terms of work or further education? Did he make the transition from high

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school to college, or from school to work without major difficulty? Did he achieve a feeling of self-reliance, self-respect? Has the patient experienced a lasting love relationship with someone of the opposite sex? What are or were his feelings and plans about marriage and parenthood during this period of his life?

### *Present Mental Status*

The mental status examination is carried out while one is interviewing the patient and is continued during the physical examination.

The psychobiologic processes illustrated in Figure 1 should be carefully evaluated in the course of the examination: (1) integrity of the sensory and motor apparatuses, (2) cognitive processes, (3) affective processes, and (4) functional concomitants of emotional states. This diagram represents a schematic attempt to depict human responses to internal and external stimuli as a psychobiologic system. This method of illustration carries the danger of oversimplification and of representing human behavior as a cut and dried, mechanical thing. While the schema does not explicitly depict psychologic defense mechanisms and unconscious motivation, it does not preclude these aspects of psychic functioning. Its purpose is to represent important functional categories which should be evaluated in examining the patient. The numerous two-way arrows in the figure signify the impressive way in which psychic processes influence each other.

These functions, illustrated in Figure 1, are evaluated by observing the patient's general appearance, the content and form of his

speech, and nonverbal behavior. In conducting the mental status examination, the experienced physician will be guided by his own associations just as he is in any medical examination. For example, if the patient appears to have undergone recent weight loss the experienced physician will keep in mind the various features of severe depression (as well as other diagnostic possibilities) as he proceeds with the mental status examination. A grossly unkempt or disheveled appearance in a middle-aged, successful businessman immediately raises the possibility of recent personality change secondary to organic brain damage or severe depression with accompanying retardation and loss of interest. These and other hypotheses are tested as the examination proceeds.

## **Outline of Mental Status Examination**

### *1. Appearance, Speech, and Motor Behavior*

Various aspects of these three categories of data are included in some detail in the remainder of the mental status examination outline given below. Nevertheless, it is useful to record at the beginning one's general observations of the patient and any characteristics which more or less immediately strike the observer as being outstanding or important. This may include a description of (1) the patient's physical appearance, including height, weight, apparent age, state of health, grooming, attire; (2) demeanor or behavior suggestive of attitudes conveyed by terms such as friendly and cordial, cool but polite, taciturn, reserved, poised, seemingly ill-at-ease, avoids eye contact, rarely volunteers in-

formation, seems affected, looks worried, looks bewildered; (3) speech characteristics such as speed, vocabulary, inappropriate use of big words, ability to express feelings and thoughts, stammering, aphasia, echolalia, use of neologisms; and (4) motor behavior such as restlessness, handwringing, pacing, waxy flexibility, stereotyped activity, echopraxia, slowness, immobility, grimacing, tics, clumsiness, unusual gait (specify), tremor, choreiform movements, paralysis, and so on.

### *2. Integrity of Sensory and Motor Apparatus*

Assessment of the organic integrity of the nervous system is an important part of the examination of the patient with emotional or behavioral difficulties. Evaluation of responses to spoken or written questions obviously must take into account the patient's ability to hear, to see, and to engage in appropriate motor behavior and speech. In the event that sensory deficits or motor weakness are present, do these conform to anatomic or physiologic patterns produced by organic lesions? Are there speech impairments, such as dysarthria or aphasia, indicative of organic dysfunction?

### *3. Cognitive Processes*

The term cognition refers to all those psychic processes by which knowledge is obtained, retained, retrieved, and used. It therefore includes all aspects of perceiving, remembering, and thinking.

*A. General Level of Consciousness.* Is patient stuporous, sleepy,

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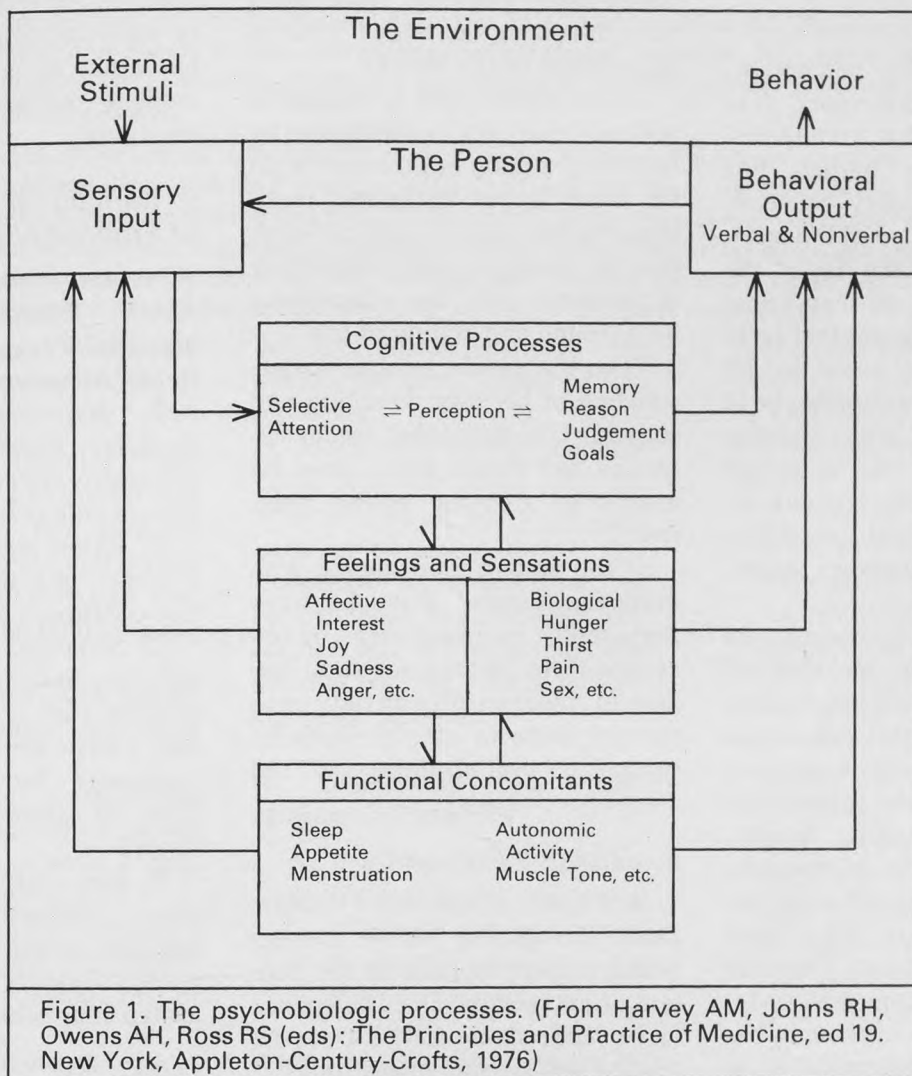


Figure 1. The psychobiologic processes. (From Harvey AM, Johns RH, Owens AH, Ross RS (eds): *The Principles and Practice of Medicine*, ed 19. New York, Appleton-Century-Crofts, 1976)

dull, or alert to his surroundings? Is he hyperalert, easily startled?

B. *Attention, Concentration, and Comprehension.* Does the patient listen to and understand questions? Is he easily distracted or preoccupied? Can he keep his mind on simple arithmetical tasks such as serially subtracting 7 from 100?

C. *Memory.* Is the patient able to recall events in the immediate, re-

cent, and remote past? The immediate recall of a series of numbers tests concentration as well as memory.

D. *Perception.* This refers to a complex process by which one is meaningfully aware of objects, ie, their identity, location, size, and state of motion. Gross abnormalities of perception may take the form of hallucinations, illusions,

misidentification of persons, abnormal body sensations, and apparent failure to perceive with one or another sensory modality.

E. *Orientation in Time, Place, Person, and Present Situation.* Correct orientation depends upon

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conscious awareness, perception, comprehension, and memory. It is well to remember that usually disorientation is only partial. For example, a patient may be accurately aware of the day of the week and month, but not the day of the month or the year; he may know what city he is in but not that he is in a hospital; he may know that he is in a hospital but not realize he is a patient. Therefore, when suspecting disorientation, the examiner carefully explores the various dimensions of personal identification, personal situation, place, time.

F. *Thinking and Speech*. In these categories are included all those remaining cognitive functions essential to successful adaptation to life: reasoning, ability to express oneself coherently, the accurate interpretation of reality, insight, judgment, and content of thought.

In expressing himself does the patient communicate the "goal idea" of his statement? Does he become lost in circumstantial details or does his line of thought become derailed by tangential associations? Does the patient talk rapidly and excessively? Does he appear to be experiencing a "flight of ideas"? Is his speech occasionally "blocked" so that he becomes suddenly silent and cannot remember what he was about to say?

To some degree, everyone's conception of reality is influenced by wishes, fears, other feelings, and mood. Is the patient's thinking so vulnerable to such influence that he has delusional concepts of the world around him, of himself, of the future? Is he suspicious of others? Does he feel persecuted, watched, controlled by outside in-

fluence? Is he grandiose or self-demeaning? Does he have delusions involving his body? What is his concept of the future?

Is the patient able to engage in abstract reasoning as manifested by his interpretation of proverbs? Can he solve simple arithmetic problems? Is his store of general information, grammar, and vocabulary in keeping with his educational background and station in life?

Does the patient have an understanding of his own condition and situation? In discussing recent activities and future plans does he appear to exercise sound judgment?

Is the patient preoccupied with particular topics? Does he have persistently recurrent ideas or obsessions? Is he compelled to engage in rituals to allay anxiety or to prevent harm to others? Does he recognize the absurdity of the compulsive rituals?

#### 4. Affective Processes

A. *Display of Affect or Feelings*. Does the patient show feelings which are appropriate to the content of his speech? Does he appear to be "affectively flat"? Does he tend to be dramatic or histrionic?

B. *Anxiety*. Are there moments when the patient appears anxious, fearful, tense, or restless? If so, are there autonomic symptoms accompanying the anxiety states?

C. *Mood*. This term refers to a prevailing and relatively enduring emotional state. There are many varieties and shades of mood. Among the important abnormal states of mood are depression and elation, which may be associated with a variety of behavioral manifestations.

D. *Depersonalization and Derealization*. Does patient have the feeling that he or his body is unreal,

that his surroundings are unreal? Does he feel estranged, suspended, or separated from his body or from his arms or legs, from his immediate environment, from his emotions?

#### 5. Functional Concomitants of Emotional States

A. *Autonomic Concomitants of Anxiety*. Dilated pupils, tachycardia, pallor, sweaty palms, and tremor are not uncommon.

B. *Hyperventilation and Its Sequelae*. Paresthesias, giddiness, and tetany are common sequelae to hyperventilation.

C. *Eating Behavior*. Implied by evidence of weight loss or obesity and confirmed by history.

D. *Sleeping*. Does patient have difficulty in falling asleep? Does he awaken early? Does he sleep fitfully? Does he sleep more than is customary for him? Irresistible urge to sleep at inappropriate times?

E. *Miscellaneous*. Fatigue, diarrhea, constipation, sexual dysfunction, amenorrhea, urinary frequency, urinary retention, muscular tension, aching, and the like.

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# Self-Assessment in Family Practice

Compiled and reviewed by Richard Sadovsky, MD, Director, Residency Program, Department of Family Practice, Downstate Medical Center, Brooklyn, NY; and R. Neil Chisholm, MD, Associate Professor, Department of Family Practice, University of Colorado, Denver.

This section of the Journal is designed to present clinical problems which focus on patient management, problem solving, and other elements integral to family medicine. The intent of this section is aimed more at teaching and learning than self-assessment as an evaluation or scoring device. Reinforcement of major teaching points is therefore included through the further discussion and supplemental references which appear on the following pages. Critical comments relating to these self-assessment materials are invited and should be submitted as Letters to the Editor.

**In Questions 1 and 2 choose the one best answer (A, B, C, D, or E).**

1. Qualities of a satisfactory relationship between the physician and patient vary from the different standpoints of patients and physician supervisors involved in student training. All the following are true *except*:

A. Physician supervisors rate diagnostic and management skills most important

B. Patients rate a complete physical examination or some physical activity as most important in overall satisfaction

C. Family physicians must be trained to recognize the importance of the "laying on of hands"

D. Almost all patients expect drugs to be prescribed at office visits

E. The patient's socioeconomic status must be considered when attempting to evaluate the content and quality of care

2. Communication is also an important factor in the physician-patient interaction. Which of the following statements is true?

A. The patient has little perceptive ability and does not recognize the physician's attitude

B. Most patients will comply with advice given regardless of their level of satisfaction with communication

C. The patient's satisfaction is

directly correlated with the amount of time spent by the physician

D. Moderately anxious patients recall less than those who are very anxious or not at all anxious

E. Regardless of education, the patient tends to remember only the first part of what is told them and the part the patient considers most important

**In Questions 3-5 specify choices as follows:**

A. If 1,2, and 3 only are correct

B. If 1 and 3 only are correct

C. If 2 and 4 only are correct

D. If only 4 is correct

E. If all are correct

*Mrs. S. has come to your office complaining that she has not had a period for two years and is depressed. She has heard about estrogen replacement therapy and asks your opinion.*

3. Appropriate indications for estrogen replacement therapy include

1. atherosclerotic cardiovascular disease after menopause

2. women under 40 years of age who lose their source of estrogen

3. nonspecific or other psychiatric illness

4. atrophic urogenital changes

*Mrs. S. finally agrees that her depression will not be helped by hormone therapy, but she is still*

*concerned about frequent disabling hot flashes.*

4. The following recommendations are important in estrogen replacement:

1. Patients with risk factors such as obesity, diabetes, and hypertension should have a careful evaluation of endometrial status prior to initiation of therapy

2. Treatment of vasomotor symptoms should be decreased in a step-wise fashion and ultimately withdrawn

3. Therapy should be intermittent, with a progestogen added daily for the last seven to ten days of each month

4. Vaginal use of estrogen does not produce physiologic blood levels of estrogen

*Mrs. S. has been put on estrogen replacement therapy for an appropriate indication. You are doing annual endometrial sampling during the course of medication.*

5. Which of the following is/are true?

1. Pap smears are adequate for the detection of early endometrial cancer

2. A significant proportion of patients with atypical hyperplasia will progress to invasive carcinoma

3. Hyperplasia is not an indication to stop estrogen therapy

4. "Breakthrough" bleeding indicates the need for immediate endometrial biopsy

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