How Safe Is the Pill? British GPs in Study

International Medical News Service

LEICESTER, England—How safe is the pill? An extensive epidemiologic study being carried out in the United Kingdom by the Royal College of General Practitioners is expected to provide definitive answers to this question within the next few years.

The study is now in its fourth year and involves more than 1,000 physicians, 20,000 users, and 20,000 nonusers, it was reported here at the annual meeting of the British Medical Association.

Dr. Clifford R. Kay of Manchester, the recorder for the study, would not reveal any morbidity findings, but he pointed out that if anything of significance had been found, it would have been announced to the medical profession.

Some findings will probably be published after 5 years, but the study has been funded until 1973 and the College hopes to obtain a grant to extend it for 5 more years, Dr. Kay said.

So far, analysis of the data has shown that oc users tend to be of higher parity and to smoke more than nonusers, but the findings that may have a bearing on the morbidity data, he noted.

Describing the background and set-up of the study, Dr. E. V. Kuenessberg of Edinburgh emphasized that the general practitioner must help answer unanswered questions about oral contraceptives.

The College recognized this as well as the fact that, in the United Kingdom, under the National Health Service, only the GP could provide reasonably documented and unbiased data.

Approximately 95% of the population is registered with GPs. The GP has a list of epidemiologically defined patients, and he becomes aware of almost all morbidity for which his patients seek medical assistance, Dr. Kuenessberg said.

About 1,400 physicians volunteered for the study and, after 3 years, 1,175 are still participating, he noted.

Each physician recruited his own subjects.

A Salute to the AAGP, Mac F. Cahal

As the trend to family practice gains momentum, let's get on record—before people forget—which and who made possible this renewed concentration on caring for people. In the past 20 years, when most efforts were bent on encouraging specialization and laboratory research, the American Academy of General Practice kept the faith. Through the Academy's efforts, there was a large body of well-trained, competent general practitioners ready to lead the way when society recognized that this is the way to bring the best care to the most people.

As the Academy votes on changing its name to the American Academy of Family Physicians, we're pleased that the timing of our first issue permits us to salute the Academy for its efforts at this historic moment.

Not one of the many dedicated participants in the Academy's efforts would begrudge Mac F. Cahal credit as the man above all who brought it all together. Mr. Cahal relinquishes this month his duties as executive director of the Academy and publisher of American Family Physician. Fortunately, he will stay on as legal counsel to the Academy. As he lightens his load, Mr. Cahal has a privilege vouchsafed few men—he can look back on his life's work and say a job well done, indeed. We consider it honor to use Volume I, No. 1 of FAMILY PRACTICE NEWS to salute Mr. Cahal for his contributions to American Medicine and to the health of the American people.
FP Residency Meets Needs of Three Young MDs

(Continued from page 1)

patients. This afternoon I'm making phone calls.

You know, I never dreamed how important the phone is to a doctor. You could go through a complete residency in a specialty and never learn this. I feel I'm really getting a down-to-earth training for the practice of medicine.

Q. Is there any special field of medicine that interests you?

Dr. McCready: Medicine and pediatrics. After my boards, I'll probably come back to the Wilmington area to practice.

Q. How would you describe the differences in the roles of the general practitioner and the board-certified FP?

Dr. McCready: I think you can talk about that only in terms of the future. Many of our interns have been FP for years. I see the FP as primary physician for all members of the family. With more years of specialized training than the GP has had an internship, the FP is capable of handling more of the family's problems than the GP. He places a lot more emphasis on the psychological and social mechanisms of the family, the interactions between family members that are responsible for a lot of its medical problems.

Specialists will be used by the FP more as consultants, and there will be fewer referrals.

Q. Out of your graduating class in medical school, how many chose family medicine?

Dr. McCready: Five or six out of 128, but I'll bet the following class had a lot more.

Q. Are you responsible for a block of families?

Dr. McCready: Yes. When Dr. Dene Walters, the director, started this program, he offered all of his patients the opportunity to become FP patients, and practically all of them did. I see those patients, plus some I've brought over from the clinic.

Q. With your clinic patients, do you try to involve the family?

Dr. McCready: Yes, I can give you a good example of that, of how we do involve them. One man reported to the clinic with emphysema as the main problem. I learned that his wife had cancer of the uterus 5 years ago. Both of her daughters are on drugs. Another is trying to get pregnant. We're now seeing all of them. One doctor can care for this family better than three or four doctors.

Q. Why did you choose community-hospital training instead of inner-city training in a university hospital?

Dr. McCready: Well, I think you should choose the institution that will offer you experience reasonably similar to the type of experience you will have in practice. An inner-city hospital has a patient population that isn't much like what I ex-

Everyone, even the government, knows we need doctors who treat people and don't hide away in medical centers doing esoteric research. The medical schools in the country, particularly in the East, have been so oriented in the past 15 or 20 years that they've done everything they could to discourage men from family practice.

Q. That's changing now, isn't it?

Dr. Walters: Yes, and changing permanently. I talked the other day with Dr. David Metcalf, from Rochester, where they have one of the best FP programs. For 10 openings, they've had over 100 applications, all from top men in grade A residencies. The Medical College of Virginia is starting a program out of Richmond, using three satellite hospitals, and they are confident they'll have no problem filling seven openings in each hospital.

Q. Are all these FP residencies more or less the same?

Dr. Walters: Well, they all follow the guidelines set down officially. But each one is flexible so that we can train men more or less for different areas of the country where needs are different.

In one program I know of there's heavy emphasis on group practice and they have enough residents to allow them to set up groups in the residency. Several small communities in New York have had a bonanza from this. Two or three men who trained together have gone out to places that haven't had a resident doctor in 20 years.

Q. If an inner-city hospital is in a ghetto area, does that mean the training there will produce a ghetto physician?

Dr. Walters: Not necessarily. In the first place, of course, there are problems working with low income, disadvantaged communities. I think every FP resident ought to have experience in this, but exclusive exposure can be avoided and must be. Here we have the opposite prob-

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**Brief Summary**

**Indications:** In the female, estrogen deficiency states including dysfunctional uterine bleeding, menopausal (menorrhagia), Krukenbrought, prostatic, vulvar, and uterine. Also puerperal breast engorgement and dysfunctional uterine bleeding.

In the male, carcinoma of the prostate.

**Contraindications:** Female genital carcinomas, primary carcinoma of the breast, estrogen-producing or dependent tumors, and uterine bleeding due to blood dyscrasias. Prolonged high dosage is contraindicated in the premenopausal patient when rhythmic ovarian function with fertility is desired.

**Precautions:** Bleeding while on estrogen may indicate either a need for dosage adjustment or the possible development of malignancy. The occurrence of irregular bleeding or spotting should be thoroughly investigated in premenopausal and postmenopausal women. Pre-existing thyroid tumors may enlarge when supplemental estrogens are given. Changes in liver function tests may be noted, and a number of thyroidal test may be altered up to six to eight weeks following the administration of estrogen.

**Adverse Reactions:** Side effects of estrogen include nausea, anxiety, somnolence, tingling, stool and water retention, breast swelling and tenderness, headaches, and break-through bleeding. Rare reactions include allergies, hydramnios, increased blood sugar levels and decreased glucose tolerance, and loss or increase of libido. Estrogen may precipitate or aggravate porphyria cutanea tarda in pre-disposed individuals. Males receiving high doses of estrogen for prostatic carcinoma may show testicular atrophy and certain signs of feminization.

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Ogen (piperazine estrone sulfate) is the last word in estrogen

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“We don’t want our residents’ experience to consist only of light-white middle income families, so we are developing the idea of admitting patients into the practice from different census areas of the community.”

Dr. McCrady: After spending a year as a medical resident seeing only clinic patients, I’m amazed at the different things I see over here in private practice—common things that I never saw in the clinic population because the people there would never have dreamt of seeing a doctor for them. Believe it or not, Dr. Walters, until last week, in your FP patient, I’d never seen a sebaceous cyst of the ear. My clinic people would not have gone to a doctor for that. That’s why it’s important to see different kinds of patients populations.

Dr. Walters: For some reason, that reminds me of a very important point in developing FP residents. It is primarily educational, not service. In this hospital, and most others, I think, there are a lot of people who would be delighted to see our FP residents take on the burden of primary care, which our hospital carries out de facto. Ultimately, we will be able to perform some of the service. People from downtown Wilmington who don’t have a doctor will be seen over here.

Q. Isn’t there some danger of an institution starting off too quickly with a lot of RF residents and letting their educational programs deteriorate into just such a service function as you describe?

Dr. Walters: There may well be. That has to be watched with care.

Q. How important in continuity of care?

Dr. Walters: That’s what it’s all about. The family knows who its doctor is. The doctor has an identifiable group of patients. Mutual loyalty develops. The most fun of all in family medicine is following the family over a period of time, watching the kids grow up, intervening when and then helping to keep the family happy and healthier.

An interview with Dr. Alva S. Baker, second year FP resident University of Maryland Hospital, downtown Baltimore.

Q. Dr. Baker, when did you decide on this specialty?

Dr. Baker: I’ve wanted to be a doctor since I was 12. I was raised in the country and always wanted to be a or. RF was just starting when I entered medical school. It seemed to be exactly what I was looking for.

Q. Were you exposed to family practice at all during medical school?

Dr. Baker: No.

Q. Some people feel that a residency in an inner-city hospital does not properly prepare you for practice except in the inner-city. Do you have an opinion about this?

Dr. Baker: I certainly do. All approved FP residencies follow an approved guideline with basic requirements and electives. I think I’m getting very adequate training here for my future practice, which won’t be in a large city.

Of course the patient in the inner-city is different. My people are poor. They’re not used to the idea of cost, patient care, or the idea of preventive medicine.

But I think I’ll be able to cope with the differences between our patients and the patients I may eventually have in my practice. The concepts of family medicine are applicable here and the experience is tremendously valuable. Most of my people are very sick and they have very limited resources. Providing them with family care is a big challenge, but I think it can be done.

Q. How do you broaden your experience, by elective?

Dr. Baker: Right now I’m on rotation in internal medicine at Lockraven VA Hospital. We also have a relationship with York Hospital, so that residents can get community hospital experience if they want it.

Q. How many residents are there?

Dr. Baker: Four in the first year and two in the second.

Q. Do many choose to go for community hospital experience?

Dr. Baker: I don’t know of anyone who has.

Q. Administratively, where does the RF residency fit in at Maryland?

Dr. Baker: In the Department of Medicine.

Q. Do you think, with the status of the RF as a board man, that his relationship with other specialists will be different from that with the other services?

Dr. Baker: Definitely. First of all, the RF has additional training and, in my opinion, will be able to handle about 85% of the problems in his practice without consultation or referral.

Q. Are you planning to go into group practice?

Dr. Baker: Unquestionably. Rather than practice solo, I’d go into full-time academic work. Solo practice just isn’t feasible these days.

An interview with Dr. William D. Hackett, second year RF resident, Hershey Medical Center, Pennsylvania State University, Hershey, Pa.

(Continued on page 26)
No Relation to Delinquency
Seen in XYY Child’s Height

International Medical News Service

ALBANY—Whether a child with XYY chromosomes is much taller than other children his age probably has little effect in determining if he will be a delinquent adult, say Drs. Ernest B. Hook and Dong-Soo Kim of the Birth Defects Institute of the New York State Department of Health and Albany Medical College of Union University.

Almost all reports of XYY individuals with antisocial behavior have called attention to the presence of large height, and the available published evidence indicates that tall stature has been present from childhood on, they point out.

This has led to the suggestion that large size per se has been the factor accounting for the greater frequency of XYY individuals in institutions for antisocial behavior.

Larger children would be more likely to be successful in fights with children of their own age and more likely to find that threats or acts of aggression would succeed, it has been suggested.

Larger children may also be more likely to be singled out of an unruly or antisocial group for censure. Larger children might also be more likely to associate with older children of the same size and be led into antisocial activity by more experienced individuals.

If any of these explanations were valid, it would be expected that large children would also be proportionately over represented in populations of boys with normal chromosomes who have committed antisocial acts.

They therefore determined the height distributions of four groups of XY boys in institutions for nonpsychotic, noncardiovascular offenders and compared them with published standards and the predicted gaussian distributions calculated from the mean and variance of the age-adjusted heights of each group.

In none of the groups were there evidence for an increased number of large individuals, they report (Science 172:284-86, 1971).

Needs of MDs Met
By FP Residency

(Continued from page 25)

Q. Dr. Hakkarinen, you’ve come from a first-year residency at an inner-city university hospital. Why did you transfer?

Dr. Hakkarinen: I didn’t feel that the population that hospital delivers care to was a representative population in the United States, and I wanted experience with patients more like the ones I’ll have in practice. Another thing, I was a division of one of the specialty departments and there was a lot of controversy among the specialties about RV concepts, and funding. Personally, I think family medicine ought to have equal status with all other specialties.

Q. Why didn’t you become an internist? You feel that internist medicine is the backbone of family medicine.

Dr. Hakkarinen: Well, I wouldn’t have learned what I need to know about pediatrics, office surgery, orthopedics, and much else. I picture myself going into practice in a semi-rural area. I’m going to have to know how to set simple fractures, how to repair minor lacerations, and I have to know my limits. There’ll be no subspecialists around the corner.

Q. As an RV, you will be board-certified. Do you think that will make a difference in your relationships with other specialists?

Dr. Hakkarinen: Probably so. But more than that, my extra training will enable me to handle most problems myself. There will be less consultation that I would need as a FP without the extra training. But the status of being board-certified is good to have.

Q. As a resident here, you’ve had a chance to observe students who learned family practice concepts during their Penn State medical education. Do you see a difference between them and your fellow-students at your previous institution?

Dr. Hakkarinen: I do think the students here are much more aware of family medicine as a workable concept. How this is changing them in their attitude toward the patient, I don’t know.