# Correspondence

**We 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 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.**

**Obstetrics in Family Practice**

*To the Editor:* With regard to the recent articles by Ratcliff et al and Nesbitt,[1,2] please permit a historical note regarding my participation on the Residency Review Committee (RRC) 1994–2000. As a member of the American Academy of Family Physicians Task Force on Obstetrics 1989–1993[3,4] and later the AAFP Task Force on Procedures 1993–1995,[5,6] I became aware that the accreditation process could improve maternity care training. During the 1970s and 1980s, many family physicians[7,8] had been deflected from the delivery suite by inadequate training.

Initiated by the Congress of Delegates, the Task Force on Obstetrics developed and implemented several practice programs with the hope of reversing the decline in maternity care by family physicians.

1. A review of the world's literature documented the scientific basis for high-quality care by family physicians.
2. The Advanced Life Support in Obstetrics (ALSO) course, developed by the members of Wisconsin Academy of Family Physicians, was nationally accepted through the endorsement of the Task Force and its recommendations to the AAFP. ALSO is now an internationally recognized curriculum.
3. In many residencies, ALSO, as a required curriculum, provided a fundamental basis for training in obstetrics that had not previously existed.

The AAFP Task Force on Obstetrics documented reports describing a lack of commitment to the teaching of normal deliveries in many family practice residencies. When the RRC approached the AAFP Directors Workshop in June of 1994, a vocal minority of directors from northeastern states and Florida attempted to deflect the agenda into a no-action posture. This move required a hand count on the floor in which approximately two thirds voted for action on the issue described by Ratcliff et al and Nesbitt.[1,2]

The AAFP Task Force on Procedures created a document on teaching obstetric ultrasound techniques to family practice residents.[9,10] In that white paper, we specified a guideline for a minimum number of sonograms, and further encouraged residency directors to start tracking specific procedures such as sonography, deliveries, and others. At graduation, each resident would be given a letter of completion with a record of the procedures. For example, the letter of completion should specify successful participation of such performance-based learning and competency-based testing activities as Advanced Cardiac Life Support, ALSO, Advanced Trauma Life Support, and others. Although this document was discussed, the guideline was not codified.

By 1995, the AAFP Commission on Continuing Medical Education endorsed a proposal for competency-based testing in specific procedural areas of the AAFP Annual Scientific Assembly. Competency-based testing modules were established in colposcopy, esophagogastroduodenoscopy, colonoscopy, endoscopic biopsy, and flexible sigmoidoscopy. These modules created an opportunity for family physicians to receive certificates of achievement if they successfully passed the standards established for competency-based testing.

In the same year, the RRC returned to the Residency Directors Workshop in Kansas City with the intention to move forward on new guidelines for 1997. These guidelines included the specific change mentioned by Ratcliffe et al and Nesbitt, ie, accreditation would require family physician role models in the residency program.

Readers might not know that the RRC for family practice contains three representatives from the American Medical Association, three from the AAFP, and three from the American Board of Family Practice (ABFP). The members are charged to represent their constituencies within the limits of their professional judgment. I sought and did not receive a formal position statement of support from the ABFP or the AAFP on this issue. Although the vote carried, this lack of written policy support by the ABFP and the AAFP has continued to haunt us on this issue.

Consequently, as we came to the final vote of the 1996 RRC, representatives for those programs that faced painful political and curriculum change lobbied hard against the proposal. Among my proudest moments during the past 30 years was the final vote and the subsequent support of the policy even by those who disagreed with it. The vote, however, crystallized the very real problems that family practice, as a medical specialty, continues to avoid.

Spin exists. The actual RRC document contains the word "some." Ratcliff et al suggest that this means "at least one." In my opinion, some implies more than one. Operationally most residencies understand that a call system of 1 physician is a self-fulfilling prophesy for failure. A clear statement by the ABFP and the AAFP would make these regulations more effective. A gentle



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**The Central "TRUTH" of a Residency**

**The residency, in any medical specialty, is the central "truth" of that specialty. Here the physician begins the process of professional identity by beginning to assimilate the medical knowledge, the clinical reflexes, and especially the psychological "set" of the specialist he or she is to become. Future learning habits, self-expectations, and professional goals are developed. It is a concentrated period of critical professional growth unlikely to be rivaled at any other time in a physician's career.**

**And, from the vantage point of the medical specialty of family practice, the residency, by programming its physician trainees, creates itself (i.e., develops an identifiable family physician specialist that makes the specialty of family practice whatever it is). Thus, the residency is critical in both the narrowest (resident) and broadest (specialty) sense.**

**Robert Dailey, MD, 1978**

Abridged and edited by Wm. MacMillan Rodney, MD, 1993, 1997b.
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**Figure 1. The central "truth" of a residency.**

reminder to their representatives on the RRC would be helpful. This reminder should prompt a uniform commitment to these principles by all faculty. See my previous comments regarding ". . . the hand that rocks the cradle."[11,12]

Data exist from the Memphis Project, which became operative in 1992, and the Rural Tennessee Demonstration Project, which became operative in 1995. Lip service is given to rural and underserved communities, with little or no acknowledgment of the importance for leadership by urban programs on the issue of scope of practice.[13,14] These urban programs are those in which medical students witness whatever the medical specialty of family practice presents itself to be (Figure 1).

In summary, the RRC represents a crossroads for the specialty. By 1989 one third of residency directors believed that maternity care should be made optional, thereby creating the family practice equivalent of a 3-year internal medicine – pediatrics track. Multiple data reflect the ability of residency graduates to perform maternity care at a national standard, but residents must be trained with enthusiasm. Anything less becomes a self-fulfilling prophesy for reduced expectations.

Theologian Reinhold Niebuhr, at the close of World War II, stated something to the effect that "if the democratic nations fall, it will be because idealists with too many illusions face realists with too little conscience." As for medical education, please consider the central truth of a residency in Figure 1.

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### Obstetrics in Family Practice

To the Editor: I am writing in response to the January-February editorial on obstetrics by Dr. Nesbitt (Nesbitt TS. Obstetrics in family medicine: can it survive? J Am Board Fam Pract 2002;15:77–9). I am reminded of the orchestra continuing to play while the Titanic was sinking. I am also reminded of my family practice residency in 1970 when several of my preceptors insisted that I could never be a real family physicians unless I did surgery. Those preceptors echoed the words of Perry Pugno, director of the AAFP Division of Medical Education, who stated in the February 2002 *Family Practice Report*, "OB care in family practice isn't going away." My preceptor physicians in 1970 assured me that "surgical care in family practice isn't going away." But of course it was going away and did go away. Dr. Nesbitt appears to be echoing the words of my 1970 preceptors.

It was clear to many physicians in 1970 that, in general, family physicians should not be doing surgery. Medicine had changed in many ways during the 1950s and

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1960s. Our leaders who began the new specialty of family medicine recognized it no longer made good sense for all family physicians to be trained in surgery. They made surgery training optional for those few physicians wanting to practice in rural or underserved areas. In fact, not only did most family physicians stop doing surgery, an entire new specialty called family practice was begun.

Many more changes have occurred in medicine during the 1980s and 1990s. Women no longer have four to eight babies, rather they have one or two. Technologic innovations, the malpractice climate, and an increased value young physicians place on the importance of family have all been major changes. This latter attitudinal shift toward the importance of family life is a difference not often recognized. Currently most young family physicians refuse to be on call at all times (now known as 24/7). The result is that these physicians are not attending the deliveries of many of their obstetric patients. Once a family physician is delivering babies only when on call, the total care of one's obstetric patient loses some its luster.

The facts speak for themselves as to whether obstetrics should remain a residency requirement. As mention in Dr. Nesbitt's editorial, our own AAFP reports that the rate of family physicians with privileges for routine deliveries has decreased from 46% in 1978 to 22.4% in May of 2000. Almost 4 of 5 family physicians are not doing obstetrics, and we are still debating whether obstetrics should remain a residency requirement. The number of medical students matching in family practice is going down, and we continue to wonder why.

Dr. Nesbitt's last paragraph states that this decline in family physicians doing obstetrics "has threatened the core mission of the specialty and put patients at risk in many rural areas." As a rural physician (and as a former residency director of the University of Minnesota Rural Family Practice Residency Program from 1994 to 1996), I would like to challenge that statement. In fact, I would state it quite differently. Our insistence on requiring all family physicians to have training in obstetrics has threatened the core mission of the specialty and put patients at risk in many rural areas.

Let me explain. I believe our core mission is to take care of our patients in the best way possible to help them achieve optimal health. Taking care of patients through their entire life cycle is not our core mission is – it is only one way of how we can take care of them in the best possible manner. For family physicians to do surgery on their patients no longer makes any sense. In fact, doing surgery on our own patients threatens the core mission of our specialty because it is not taking care of our patients in the best way to help them achieve optimal health.

Analogous to the argument for family physicians not doing surgery, multiple factors indicate that, in general, we should not be doing obstetrics. In fact, I believe that our insistence on requiring all family physicians to have training in obstetrics is threatening the very existence of family medicine. Statistics show that medical students are finding family medicine a less appealing specialty, and one reason is required obstetric training.

As a rural family physician, I have not found good data indicating the family physicians not doing obstetrics has "put patients at risk in many rural areas." Most of the data would indicate the opposite. Several quality assurance studies have shown that hospitals performing fewer than 500 to 1,000 deliveries a month have a higher complication rate and a higher mortality rate for mothers and babies. Just as our leaders did in the late 1960s, it is once again time to reinvent our specialty, join with other primary care physicians, and diversify our training to fit the needs of the individual practitioner. Most businesses change at least every 30 years, and it might be time for family practice to make some core changes. The Titanic is sinking. We need to quit playing our old songs and get serious about saving family medicine.

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