By adopting the role definition described above as our mission statement and promoting the unique qualifications and perspective that Family Medicine brings to current discussions of primary health care delivery and health care policy, we position our discipline for a leadership role in our national health care system.

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The Numbers Quandary in Family Medicine Obstetrics

To the Editor: The article "Intention Versus Reality: Family Medicine Residency Graduates' Intention to Practice Obstetrics" by Barreto et al[1] illustrates the decline of obstetrics in family medicine. The accompanying editorial by Rayburn[2] mentions a key barrier to this scope of practice: the lack of standardized pedagogy and supporting research to ensure quality care provided by family medicine obstetric physicians. The question becomes not only whether a sufficient number of family medicine physicians practice obstetrics, but whether our training and standards are rigorous enough to deliver quality care in the face of rising maternal morbidity and mortality.[3]

Regrettably, obstetric training in family medicine is inconsistently measured and inconsistently required. Several studies have concluded that family medicine physicians can deliver quality care, comparable to that provided by obstetricians, but unfortunately these studies are outdated, based in other countries, or limited to a few regional medical centers.[4–7] The Accreditation Council for Graduate Medical Education recently lowered the number of deliveries that family medicine graduates have to complete in order to graduate from residency. The number of babies that family physicians deliver declines throughout the course of their careers, as does the percentage of physicians who choose to recertify.[1,8] Fellowship programs vary widely regarding curriculum and graduation requirements.[9] If obstetric practice is to survive in family medicine, we must consider the forces driving these decisions as we move forward.

Family medicine physicians who provide obstetric care offer a valuable service, especially in underserved rural areas of the United States. To align our outcomes with our intentions, however, we are faced with the option of adopting standardized and studied practices or abandoning obstetrics all together. The resolve of family medicine physicians to continue obstetric practice could be strengthened with specialized tracks in residency programs followed by standardized fellowships with consistent requirements. Rigorous studies of the outcomes of deliveries by family medicine physicians would permit self-evaluation and improvements in training. Insistence on quality and robust preparation must supersede concerns about the numbers of family physicians practicing obstetrics. The number of family medicine obstetricians may continue to decrease, but let them be the few and the proud rather than the many and the untested—our patients deserve nothing less.

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The above letter was referred to the author of the article in question, who offers the following reply.

Re: The Numbers Quandary in Family Medicine Obstetrics (J Am Board Fam Med 2018;31:169.)

To the Editor: Worth[1] brings up some important points including outcomes and training. As described, there are several studies that demonstrate equivalent outcomes between family physicians and obstetricians. Worth voices concern about the paucity in outcomes literature based on various limitations. Of the 3 recent studies cited, 1 is in Canada, which, while there are clear health care differences, presumably the patients and procedures are not so different that we must exclude it.[2] The other 2 articles cited had over 14,000 patients and found a significantly lower cesarean-section rate among patients delivered by family physicians with all other outcomes equivalent whether delivery was attended by a family physician or obstetrician.[3,4] These studies support previous research documenting equivalent outcomes, and leave us wondering how many times does equivalency in outcomes need to be demonstrated. However, with recent changes in family medicine training requirements, we do agree that there is a need for new studies to assess how these changes may affect outcomes in obstetric care.

Regarding training standards, family medicine is a broad field with many competing interests. Decades of work conducted by the family medicine community, Accreditation Council for Graduate Medical Education (ACGME), and Family Medicine Residency Review Committee (RRC) has been done to ensure competency is achieved in each of the Family Medicine domains of practice, including obstetrics. Despite the lowered ACGME obstetric requirements, more intensive training in obstetrics via electives, mentoring, or fellowship is available for physicians interested in increasing their obstetric experience.

Our finding that 23% of recent graduates want to include obstetric deliveries is encouraging both for believers in the full spectrum of family medicine and for patients who are facing higher maternal and infant morbidity.[5,6] A study of over 2.6 million births in California found that rural women who were able to deliver in a rural hospital had decreased rates of morbidity and mortality.[7] However, rural hospitals continue to close labor and delivery units.[8] If a local family physician provided obstetric care at a local hospital, women would not have to travel such distances and may see improvement in outcomes.

We agree that all patients deserve nothing less than highly qualified, competent physicians. Our concern is not simply that the numbers of family physicians delivering babies is decreasing. Our concern is that at a time of national shortage of obstetric care, there are 2000 family physicians who intended to provide obstetric care after graduating and are being prevented by barriers that have nothing to do with their training or competence. We might improve maternal and infant morbidity if the family physicians who are interested and competent in obstetric care are able to provide that care.

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