

COMMENTARY

Family Medicine and Obstetrics: Let's Stop Pretending

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It is time to stop pretending that delivering babies is one of the core activities of family medicine.

At no time in the history of American family medicine have the majority of the members of the American Academy of Family Physicians (AAFP) delivered babies. A study in 1982 found that approximately 44% of family physicians delivered babies¹, another study reported 43% in 1986², another 26% in 1993³, and the most recent data from the AAFP states the current number is 17.1%.⁴ The way forward from these trends should not be to continue business as usual.

Barreto et al⁵ found that 13% of 2016 family medicine residency graduates deliver babies. Almost half the respondents were not interested at all in obstetrics practice (889/2018). Of those left who did not deliver babies, 60% mentioned lack of availability of jobs where family physicians in practice deliver babies as the reason and 60% mentioned lifestyle considerations, followed by malpractice costs and privileging challenges.

These realities have implications for family medicine residency education and the basket of services provided by its graduates.

Reforming Education

Recent experiments in family medicine residency education—the P4 project^{6,7} and the Accreditation Council for Graduate Medical Education Length of Training Pilot (ACGME LoT)⁸—have allowed for experimentation in the length and content of

family medicine residencies. Our study of our early P4 graduates who completed a year of extra training in maternity care found they were much more likely to provide maternity care services, plus they were more likely to provide a wide basket of other services including caring for hospitalized adults and children, and performing hospital-based procedures.⁹ We have heard similar anecdotes from other programs offering extra training, and there is a literature on the effect of traditional obstetric fellowships on the provision of maternity care in practice, which found that roughly half of their graduates work in rural areas, at least for part of their early career, and roughly half become residency faculty.^{10,11}

Our profession has had a considerable lively discussion of the role of maternity care in residency education, its requirements, and its impact on graduates' provision of these services.^{10–15} Residency characteristics associated with a higher likelihood of its graduates delivering babies included family medicine maternity care preceptors, 80+ deliveries during residency, and greater autonomy in maternity care decision making.¹⁶ Cesarean sections may be a particularly important component of extended training options, as previous research reported an association between C-section training and its provision in rural practice.^{11,17} We agree that all family physicians should know the basics of vaginal deliveries for at least 3 reasons: a positive experience in residency might convince the learner to consider maternity care on graduation; patients will ask questions about maternity care concerns even if the physician does not provide the service; and the physician might be called on to deliver a baby in an emergency. But for family medicine to continue to market itself as a comprehensive provider of maternity care services is misleading and undermines the public's perception of our specialty.¹⁸ Did our specialty ever really think that 40 vaginal deliveries was adequate to prepare a graduate to provide

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high-quality maternity care, especially if approximately one third of US deliveries are by cesarean section?

Rural Health

The American College of Obstetricians and Gynecologists (OB/GYN) recognized that most rural counties have no OB/GYNs, who vastly prefer to practice in urban settings.¹⁹ A survey of family medicine and OB/GYN residents confirmed that family medicine residents were more likely to provide maternity care services to rural areas²⁰ and other studies have found that family physicians provide a disproportionate share of rural deliveries.^{9,21}

Greater travel distance to maternity care services is associated with worse perinatal outcomes.²² But rural hospitals are closing, especially labor and delivery units, a trend that has recently been reported in the lay press.²³ It comes as no surprise that the decreasing percentage of family physicians providing prenatal and intrapartum care in rural areas has contributed to an increased number of rural communities with no local access to maternity care.²⁴ Rural areas that lack local obstetric services are associated with less adequate prenatal care, higher rates of preterm delivery, infant mortality, and complications during delivery.²⁵ In rural counties not adjacent to urban areas that lost obstetric services, increases were reported in out-of-hospital and preterm births and births in hospitals without obstetric units the following year.²⁶

It is inconceivable that in our lifetimes family physicians will provide the majority of deliveries in urban America. Where might family physicians still deliver some urban babies? They can and should in family medicine residencies, a few remaining friendly oases in the Pacific Northwest, and a few independent inner city organizations serving vulnerable populations through Federally Qualified Health Centers or in some cases faith-based non-governmental organizations.

But rural America is different. It makes no sense for OB/GYNs to deliver the majority of those babies both for reasons of professional life and the business model. There are simply not enough cases in many rural communities to feed the OB/GYNs enough business to thrive with capable OB/GYN partners in those communities. Family physicians can be kept busy when they are not providing

maternity care by addressing all the other patient concerns not limited by symptom, disease, gender, or age; OB/GYNs cannot. A recent survey of rural hospital executives found the more isolated and smaller volume hospitals are much more reliant on family physicians to deliver babies, but they are still present in the larger rural hospitals.⁹ We know that maternal or child outcomes are similar between family physicians and OB/GYNs performing cesarean sections^{27,28}, so that issue is moot.

The Way Forward

Everyone who cares about the wellbeing of mothers and their babies from vulnerable populations (in this case, mostly rural, but some urban) should advocate for 2 things. First, after recognizing that only a subset of family physicians are adequately trained and capable of providing comprehensive maternity care services in these isolated and/or underserved environments, to advocate that their residency education be better supported so that more of them can provide these services in practice, which will often require extra training time. The OB/GYN world has even commented on the negative impact of the duty hour rules on preparing physicians in their residencies for practice after graduation.²⁹

Think of extra maternity care training as like a merit badge in scouting. All family physicians possess key characteristics—a broad base of knowledge and skills to manage over 1600 symptoms and diagnoses³⁰ possessed by physicians who make medical care decisions guided by a deep knowledge of the whole patient combined with a comfort with uncertainty³¹—but only a few have had the extra training to competently, confidently, and independently graduate from the training environment to deliver maternity care services. The ACGME LoT experiment may shed further light on the educational specifics required to achieve this outcome.⁸ Extra training opportunities in 4-year residencies should be funded consistent with standard graduate medical education funding as 1 option (or better yet, better) and traditional obstetrics fellowships should also be an option.

The second advocacy need is for family medicine graduates to have sustainable rural health care systems to work in, both in payment for physician services and to rural hospitals. All physicians thrive when they have competent and trusted colleagues

to work with, which makes the 3:00 am deliveries that much more tolerable. This may be especially important for rural women family physicians.³² Unfortunately, the realities of health care financing often do not support this physician or hospital infrastructure. Closed rural obstetric units were smaller units in lower-income communities^{24,33}, but an additional family physician per 10,000 in the community was associated with a 38% decrease in the odds of unit closure.²⁴ The lack of family physicians delivering babies is especially a problem of the Eastern United States.⁹ The markedly higher medical malpractice costs in many Eastern states without tort reform probably has a large role in this finding.³⁴ Decreasing malpractice costs is a key component of both expanding maternity care training opportunities in residencies and encouraging young family physicians to deliver babies in practice.³⁵ Funding of Medicaid and nonfee-for-service payment mechanisms (rural health clinics, e.g.) should also be improved.

Addressing recent graduates' concerns that they do not see family physicians delivering babies in the "real world" can only be addressed with an enhanced residency experience in maternity care and a viable practice to work in after they graduate. Just as in other issues of health care disparities, being born in rural or urban underserved America should not be a reason for babies and their mothers to have worse outcomes.³⁶ More well-trained and supported family physicians delivering babies, and the rural hospitals they work in, are the best solution to this problem.

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