Re: Family Medicine and Obstetrics: Let's Stop Pretending (J Am Board Fam Med 2019;32: 279.)

We read with interest the article by Richard A. Young et al[1], "Family Medicine and Obstetrics: Let's Stop Pretending." This is a nice article describing the state of obstetrics in family medicine residency programs and practice thereafter. While our observations are similar, our conclusions are different. The small number of family medicine residents who choose to offer obstetrics as part of their practice has made a great impact on rural, underserved Alabama and helping reduce our high infant mortality. We concur with basic obstetric training for the reasons mentioned, especially for residents who are or may become interested in providing maternity care after residency.

Our experience in the southeast is that those family medicine residents who want to practice obstetrics often complete an obstetrics fellowship to obtain full obstetrics privileges including cesarean section. In other areas of the country, residents practice obstetrics right after residency training. Whether full-service obstetrics with cesarean section or limited privileges with vaginal deliveries only or even prenatal care only, their service is needed. Seventy-eight percent of our fellowship graduates have practiced obstetrics in a rural area.[2] Family physicians practicing obstetrics often practice in rural areas while Obstetrician (OB)/Gynecologist (GYN) graduates usually practice in urban areas.[3] Family physicians including those who practice obstetrics are rarely sued.[4] Malpractice insurance providers in Alabama often quote rates for family physicians practicing obstetrics of one third to one half of what obstetrician/gynecologists pay.[4] Maternal outcomes are similar for OB/GYN physicians and family physicians.[5,6] Family physicians practicing obstetrics have lower cesarean section rates than OB/GYNs because they perform more vaginal births after cesarean sections, which translates into shorter hospital stays, fewer complications and less expensive care.[7]

According to Rayburn, 50% of the counties in the United States have no obstetrics provider leaving some 10,000,000 reproductive-aged women without maternity care, primarily in rural, underserved America.[3] Family medicine physicians trained in obstetric and neonatal care is the answer to reducing maternal and perinatal morbidity and mortality in rural, underserved areas of this country.[2]

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doi: 10.3122/jabfm.2019.02.180329

Response: Re: Family Medicine and Obstetrics: Let's Stop Pretending

To the Editor: We thank Avery et al for their response to our commentary.[1] While they state that, "… our conclusions are different," we find that their points more confirm our points than refute them. We agree with all their positive statements about family physicians delivering babies, especially in rural areas. Our basic statement was that most family physicians do not provide obstetrics

(OB) because of 2 primary realities: lack of adequate training and a hostile work environment.

On the training issue, they actually agree with us that for a family physician to competently provide obstetrics, extra training is required. Current options for this extra training includes formal OB fellowships after a standard family medicine residency (their model), extra OB training that is part of a longer family medicine residency duration (eg, John Peter Smith Hospital in Fort Worth, Texas and the Greater Lawrence Family Health Center in Lawrence Massachusetts), and residencies that emphasize obstetrics in their 3-year curricula (eg, various Via Christy Family Medicine Residency programs).

On the work environment issue, they mention their "… experience in the southeast …," which is fascinating because a recent study found that several southeastern states have remarkably few rural hospitals that have family physicians who provide obstetrics, especially compared with the western United States.[2] A recent report of the current state of care for pregnant women in rural Alabama concluded that the number of rural hospitals providing obstetric services has fallen from 45 in 1980 to 16 in 2017, which explains why many of these women have to drive more than an hour to reach a facility to deliver.[3] The Executive Director of the Alabama Rural Health Association was quoted as believing that the access issue helps explain why his state has 1 of the country's highest caesarean rates—35.4% of its births in 2015. The author's study of their own OB fellowship graduates (17 over 25 years) show that many areas of rural Alabama have been left uncovered.[4]

We agree with these authors that family physicians with substantial obstetrics training are the best solution for the health of rural pregnant women and their babies. Training options to achieve this goal currently exist. A supportive work environment does not.

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doi: 10.3122/jabfm.2019.02.180362

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

Re: The Complex Interpretation and Management of Zika Virus Test Results

Dear Editor, we read the publication titled, "Complex Interpretation and Management of Zika Virus Test Results" with great interest.[1] Lin et al concluded that, "*Women with a high pretest probability of Zika virus infection should still receive enhanced prenatal monitoring and newborn evaluation, regardless of the test result. An appropriate interpretation of results depends on what tests are used, patient characteristics, and reasons for testing.*[1]" We would like to discuss and share ideas on this issue. First, it should note that most cases of Zika virus infection are asymptomatic.[2] In the asymptomatic case, the laboratory is the necessary approach to get the diagnosis. The interpretation of the test result depends of several factors as noted by Lin et al.[1] Nevertheless, there are also other considerations in clinical pathology that should be taken. First, the quality control of the laboratory test is necessary. The false-positive and false-negative results are possible and this problem can lead to incorrect diagnosis. The good example is the false-positive Zika virus test due to cross reaction by other arbovirus such as dengue.[3] Nevertheless, the concurrent Zika virus infection with other infection is also possible and the diagnosis of the concurrence is more difficult. Second, the diagnostic limitation of the Zika virus diagnostic test kit should be mentioned. The different sensitivity and specificity of different available diagnostic test kits is observable.[4] According to the external quality assessment study, the surveillance showed difference in analytic sensitivity and specificity of the test methods in different international medical laboratories.[5] To correctly interpret the Zika virus test result, the practitioner should aware of the quality and standards of the clinical laboratory of the medical center.

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