

COMMENTARY

A Response to the Decline in Family Practitioners Performing Obstetric Care

Jill Schmitt, DO, and Leah Cecil, DO

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After we graduated from the Beaumont Troy Family Medicine residency with strong training in obstetrics, we started a new hospital supported practice in the northern suburbs of Detroit, MI about 30 minutes from our base hospital. As a 3 female physicians practice, we wanted to provide prenatal care and attend our patients' deliveries in the hospital similar to what we did during residency training. We shared hospital call with 2 other Family Physicians and had great obstetric backup. We enjoyed practicing full scope family medicine; we had many newborns in our practice and built strong relationships with our pregnant patients and their families. After a few years, we lost 1 physician due to relocation. While we continued with a shared call schedule, we often found ourselves attending deliveries of our personal patients, even when not on call. Although our number of deliveries was overall small, the possibility of a patient going into labor at any time and the guilt and pressure we put on ourselves to attend our own patient's deliveries added to the stress in our already busy practice and lives. We eventually decided in 2016 that continuing to attend deliveries was not practical for a 2 physicians practice.

We continued to provide prenatal and postpartum care in the office. This model worked well for about 3 years. However, as more time passed since

we attended deliveries, we felt disconnected from labor and delivery atmosphere, consistently felt that our knowledge and skills were being questioned and criticized by the obstetricians caring for our patients in the hospital. We felt that the obstetricians did not want to support this model of care.

Around the same time, we moved from a hospital employed to a private practice, where we could not accept Medicaid insurance due to low reimbursement. This resulted in a significant decline in our obstetrics volume. Having 5 to 10 pregnant women in the practice each year, we found ourselves having difficulty keeping up with new and changing prenatal care guidelines, while we tried to manage our new practice. We started to worry about providing less than best care and about the increased risk of litigation. We stopped providing prenatal and postpartum care by the middle of 2022.

We enjoyed providing prenatal care and do miss it, especially the bond created with our pregnant patients and the opportunity to get to know them better during newborns and baby visits. We also appreciated the variety that it added to our schedules.

In this issue of the *Journal of the American Board of Family Medicine*, Aimee Eden et al,¹ discuss in their policy brief the decline in the number of family physicians practicing obstetrics, which is followed by a similar decline in those providing prenatal care. The policy brief also discusses possible solutions to the decline in family physicians providing prenatal care. We agree that financial support would have been an attractive incentive for us to maintain our obstetric practice. Lack of financial compensation for the amount of calls, conferences, reading, and missed personal time was a

From the Arcturus Healthcare PLC Washington, MI (JS); Corewell Health East Troy, MI (LC).

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Corresponding author: Jill Schmitt, DO, Arcturus Healthcare PLC, 64321 Van Dyke Rd, Beaumont Clearwater Family Practice, Washington Twp, MI 48095-2578 (E-mail: jill.schmitt@corewellhealth.org).

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driving force behind our decision to eliminate obstetrics from our practice. We also agree that a model of care that was supported by the hospital administration and hospitalist/laborist physicians would likely increase our willingness to provide prenatal care. However we found the lack of support in our system ultimately made this model of care more problematic and unsustainable. Finally, we hope new policies will be passed to ensure protection of work-life balance for physicians and to provide some

protection for the increased demands placed on primary care physicians in the U.S.

To see this article online, please go to: <http://jabfm.org/content/36/4/690.full>.

Reference

1. Eden AR, Taylor MK, Goldstein JT, Barreto T. The workforce providing prenatal and postpartum care decreases when family physicians stop attending deliveries. J Am Board Fam Med 2023;36:685–686.