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COMMENTARY

From Pipeline to Practice: Supporting Family Physicians as a Maternal Health Solution

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Maternity care in the United States is in peril. Maternity Care Blueprints have outlined the need for transformation including reexamining the infrastructure of our health care systems, redesigning reimbursement, and building partnerships between hospitals and the communities they are meant to serve.[1,2] Safe, dignified maternity care includes but is not confined to intrapartum care alone—it begins before conception, extends through pregnancy, intensifies in birth, and continues into the powerful months of the 4th trimester.[3] Family Medicine is uniquely equipped for this work and is a vital part of the maternity care workforce.[4]

In 2024, 48% of all US counties lacked a practicing obstetrician-gynecologist (OBGYN) and over 35% were designated as “Maternity Care Deserts” by the March of Dimes.[5] Between 2010 and 2021, the ratio of OBGYN’s to births declined in rural counties, while urban counties experienced a concurrent increase, further widening the rural–urban workforce gap.[6] The Health Resources and Services Administration (HRSA) Data Workforce Projections estimate a national shortage of up to 7,500 OBGYN’s in the next decade, with only six states expected to maintain an adequate supply. There is also an increasing trend of sub specialization in OBGYN, so the gap for maternity care may be even greater than projected.[7] Family physicians (FPs) account for 1 in 4 obstetrical clinicians in rural counties and 1 in 20 in urban areas.[5] Family medicine has an essential role in the provision of comprehensive, equitable, high-quality maternity care, yet the family medicine maternity care workforce continues to decline.[8] The policy brief authored by Barr et al. in this issue identifies an encouraging trend in the practice of early career FPs, as well as maternity care interest amongst family medicine residents. This commentary challenges us to adopt bold and innovative approaches to ensure comprehensive maternity care training and to provide on-going support for our early career colleagues practicing maternity care.

Building the Pipeline

Despite growing interest in health equity, community-based care, health systems transformation and reproductive justice, medical students (like other health professional trainees) have shied away from careers in maternal health. It is possible that the fragmentation of perinatal health into separate spaces such as obstetrics, pediatrics, and primary care limits sufficient exposure to maternal health in training. Changing federal and state reproductive health policies and uncertainty in many states following the Dobbs decision may further diminish entry into these specialty areas. Health professional schools including medical schools should introduce early longitudinal exposure to perinatal care through shadowing or case-based learning, mentorship with senior students or residents or the creation of pathways in primary care, maternal health or perinatal research.

Within family medicine, residency training plays a substantial role in whether graduates provide inpatient or outpatient maternity care in future practice.[9] Approximately 40% of all US family medicine residencies report no recent graduates that chose to include intrapartum care in future practice, and more than 1 in 4 reported that recent graduates do not provide outpatient perinatal care.[10] Other programs provide robust exposures with an independent family medicine obstetrical service or other focused perinatal training opportunities. We encourage more residency programs to prioritize creating regional partnerships so that interested residents have access to high volume training experiences needed to attain knowledge and skills for future maternity care practice.

Barr et al. utilized a novel assessment of resident intentions during their PGY-2 year and discovered that a robust proportion (41%) intend to provide prenatal care and nearly a third (30%) will complete the new ACGME benchmark for competency in comprehensive maternity care. Previous studies have demonstrated that residents who achieve these training goals are more likely to include perinatal care in their future practices.[11] With over 5,000 new family medicine residency graduates annually in the US, these percentages would translate to hundreds of additional maternity care clinicians. These early career physicians need jobs in practices and health systems that appreciate and value their comprehensive skill set. Many health systems

silo FPs to outpatient settings and consolidate intrapartum care in the hands of OBGYNs and Certified Nurse Midwives (CNMs). This approach erodes the family medicine maternity workforce by creating distance between FPs and their OBGYN and CNM colleagues, limiting birth volume needed to maintain clinical competence, and fractioning maternity care to primary care transitions. The resulting absence of strong career role models affects trainees and perpetuates a cycle that undermines the pipeline needed to address the shortage in maternity care. We encourage health system leaders to create academic and community-based opportunities for FPs to provide perinatal care with sufficient volume to maintain inpatient and outpatient skills.

Family medicine maternity care fellowships offer surgical and non-surgical training to FP's and fellowship completion is highly associated with scope of future practice.[12-14] It is anticipated that Rural Health Transformation Program funds will be used in some states to increase the number of fellowships in maternity care. Additionally, fellowships could be adapted to offer training options to FP's who are seeking to reenter obstetrical practice or enhance outpatient maternal health skills. Offered as part-time opportunities with distance learning components, FPs could remain in practice without having to leave their patients or communities.

Supporting Practice

A primary reason FPs do not practice maternity care is that available job opportunities do not include this scope of care.[8] The addition of FPs to the maternal health workforce will only be effective in increasing the overall number of clinicians if they are entering at a faster rate than those leaving the field. To ensure this, policymakers, payors and healthcare systems must support current and future maternity care clinicians. There are many levers that can help achieve this goal and we support the call for higher reimbursement, malpractice subsidy and reduced institutional barriers including hospital privileging for FP's who achieve competence through residency or fellowship training. Early career FPs should be matched with mentors to help them grow clinically and professionally in an evolving practice landscape. State governments looking to address maternal health access in their states should follow the examples of other states in providing malpractice subsidies for health systems and physicians who provide maternity care in rural or underserved regions.

Learning collaboratives are becoming increasingly prevalent and offer potential for fostering professional identity, enhanced quality and collective advocacy. These networks can be leveraged to support early career family physicians in incorporating and sustaining the provision of high-quality perinatal care within their communities. We highlight two collaboratives – one on the West Coast and one on the East Coast, which demonstrate the value of these networks.

- The **N**orthern **C**alifornia **P**regnancy **E**ducational **C**ollaborative (NPEC) began in 2021 with a group of maternity care leaders from residency programs in the UCSF Family Medicine Educational Alliance. Since inception, its geographic reach has expanded to include other programs in Northern California. Sixteen programs belong to the collaborative, and approximately 15 faculty have been active in monthly meetings. Participants lead a diverse array of training programs: community-based and university-affiliated, rural and urban, high and low-volume programs. Some programs have been in place for decades, while others are building new residency or fellowship programs. Monthly meetings offer space for peer support, clinical and professional mentorship, and collective maternity care advocacy at state and national levels. Members have collaborated on writing letters for publication and presented topics at the Annual Society of Teachers of Family Medicine Spring Conference. Collaborative leaders advocated for revisions to the 2023 ACGME maternity care requirements and submitted California Academy of Family Physician (CAFP) Resolution A15-26, "Expand FM-OB to address maternity care deserts", adopted in March 2026.
- The **I**nnovations for **M**aternal and **P**erinata**L** **C**are **I**mprovemen**T** (IMPLICIT) Network is a maternal child health learning collaborative that is made up predominately of family medicine residencies in the Northeast and Mid-Atlantic states. Established in 2003 by a group of academic maternity care faculty, IMPLICIT was created to support clinicians and trainees in delivering evidence-based pregnancy care. Over time, its scope has expanded to focus on quality improvement processes and the implementation of care models designed to strengthen maternal health screening and clinical services within primary care settings.[15] Now with over 50 active sites in 12 states, IMPLICIT offers connection through data sharing and site support, CME eligible webinars and biannual Network meetings where participants collaborate to share best practices, generate scholarly project ideas, and identify future educational and training needs.

Support for FPs in maternity care requires more than training clinicians; it also depends on strengthening the evidence base that underpins their work. Although research over the years has examined the role of family medicine in maternity care[16] these efforts have not yet been sufficient to drive meaningful system-level change. We urge funders to support robust research examining the role and impact of family physicians in maternity care and to invest in training the next generation of researchers focused on this critical area.

Conclusion

In the nascent phase of our specialty less than half a century ago, over 40% of FP's were attendings births. As Barr and others demonstrate, the growth, breadth, and complexity of both primary and maternity care will prohibit that degree of participation in future generations. However, reclaiming maternity care as a core part of family medicine

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may be what our nation needs from our specialty at this moment. No other clinician group is as well equipped to deliver integrated, comprehensive, and preventive care across the continuum of pregnancy and beyond. Support for family physician maternity care clinicians remains insufficient; it may have been too little in the past, but we must ensure it is not too late for the future.

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Conflicts of Interest

None.

Associated Article

Petty A, Barr WB, Morgan ZJ, Bazemore A. Early career family physicians continue to provide maternity care and deliver babies. 2026(39)1.

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