Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints might prevent this in some cases. The problem is compounded in the case of a bimonthly journal where continuity of comment and redress is difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Family Practice Maternity Care

To the Editor: With regard to the recent article by Larimore and Reynolds,[1] I commend the authors for eloquently outlining the barriers encountered by family practice residents seeking training in the delivery of babies. During my recent 1-year family practice fellowship in obstetrics, I also saw firsthand the "demotivation" of family practice residents regarding training in obstetric skills and the incorporation of obstetrics in later practice. My experience with family practice residencies in the Navy has been decidedly different. Having trained in the Navy and now serving as a member of the teaching staff at a Navy residency program, I have seen family practice training programs successfully train family physicians to provide outstanding obstetric care. There are several important reasons why civilian and Navy programs differ.

1. *The patient populations differ tremendously.* In the Navy our deliveries are drawn primarily from the active-duty members and their dependents, a relatively low-risk population. At the civilian hospital where I did my fellowship, the resident teaching cases came from several county clinics and were a mixture of low-risk and some very high-risk populations. Also, the Navy programs are located at community hospitals with level I nurseries. Because of the constraints imposed by our nursery facilities, true high-risk obstetric patients are referred to other hospitals. Because of these two factors the Navy patient population is ideal for family practice obstetrics.
2. *There are no other residency programs at the hospitals where Navy family physicians train.* There is no competition, therefore, with obstetric residents for deliveries. It has been my observation that, generally speaking, family practice residents get the best procedural training when they do not have to compete with other specialty residents.
3. *There is support for family physicians delivering babies at all levels of the Naval hospital command structure.* The family practice department at our hospital provides about 40 percent of the prenatal care and deliveries on a monthly basis. Additionally, family practice residents see patients in the obstetrics clinic and are involved with the care and delivery accorded to all obstetric patients in the hospital.
4. *There is a sense of urgency about learning obstetric skills in the Navy.* Family practice residents must be prepared to go, quite literally, to the ends of the earth and provide prenatal and obstetric care. Most family practice faculty at our teaching programs have been stationed where the family physicians provide primary, in-house coverage for labor and delivery with a backup obstetrician on call. It only takes a few "sea" stories from a staff physician with such experience to convince a resident that the treatment for postpartum hemorrhage and shoulder dystocia will be a part of his or her practice of family medicine.

Most importantly, residents need faculty mentors who are doing the full range of family practice, including obstetrics. In the Navy essentially all family physicians deliver babies. In contrast, at the civilian hospital where I did my fellowship, no family physician on staff delivered babies. Without a strong family practice presence in the labor and delivery suites, there is no counterbalance to the demotivational factors described by the authors. It is time that we, as family physicians, assumed the responsibility for the mentorship of our physicians in training in the care of expectant mothers and the safe delivery of the next generation of children.

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References

1. Larimore WL, Reynolds JL. Family practice maternity care in America: ruminations on reproducing an endangered species — family physicians who deliver babies. J Am Board Fam Pract 1994; 7:478-88.

To the Editor: As family physicians at Group Health Cooperative of Puget Sound with busy obstetric practices, we have been touched by how many of our patients after delivery will distill their thanks into two common statements: "Thanks for believing in me," and "Thanks for being there." It is our belief that patients will confer the privilege of attending birth on any qualified provider who embodies the essential qualities of *faith* and *presence*.

At Group Health Cooperative, family physicians, obstetricians, and midwives work together in a well-integrated family-oriented system that honors the diverse needs of its patients while creating an environment of satisfaction and mutual respect for providers. Some of our family physician colleagues who were trained in this system do not provide obstetric care because they do not enjoy it or because they choose to avoid the lifestyle that maternity care demands.