It seems to us a given that family physicians are qualified to provide excellent maternity care services, particularly in settings where specialist obstetricians are readily available. (Of course, this paradigm is really true of all areas of family medicine.) In this vein, we wholeheartedly share the point of view of Larimore and Reynolds in their recent article "Family Practice Maternity Care In America: Ruminations On Reproducing An Endangered Species — Family Physicians Who Deliver Babies" (JABFP 1994; 7:478-88).

Unfortunately, we are very disappointed at the failure of the authors to present a scholarly or even well-written argument. Despite a bold title and an imposing 126 references, the article does not meet evidence-based standards. It is characterized by unsubstantiated opinion, grandiose claims, and trite statements. As a result, the article impedes the advancement of family medicine in the area of maternity care and also calls into question the academic standards of this journal.

Some examples:

1. "... family physicians in rural locations, by choosing not to provide maternity care, might be contributing to an increase in the infant death rate." Despite a cryptic reference to unpublished research, this is an outrageous assertion of possible cause and effect.
2. "Birthing is intrinsic to the formation of the family." This statement is as enlightening as saying we all come from inside our mommies' tummies.
3. "Does family practice have a place in future maternity care in the United States? Absolutely!" Cheerleading statements such as this are interspersed throughout the article and are inappropriate for scholarly writing.
4. A variety of assertions about the quality of family medicine-based maternity care contain multiple references to articles, implying strong substantiation. We are familiar with the cited articles and most of them do not meet rigorous standards themselves.

Let us avoid pseudoscience and anthropologic analogies and condense the article to three points, none of which seems to require referencing:

1. Family physicians can provide high-quality maternity care.
2. Insofar as family physicians are the only providers who can provide true continuity of care for mothers, infants, and families, we have something unique to offer to an integrated system of maternity care.
3. Lay persons and professional providers working together need to form better integrated systems of maternity care in the United States.

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The above letter was referred to the authors of the article in question, who offer the following reply:

To the Editor: We are pleased that Drs. Madwed and Madwed enjoy an active practice in childbirth care, that they have the blessing of practicing in a supportive environment, and that they recognized the hyperbole of our paper. Their last three points are an excellent summary of what we have written.[1]

The Madweds might have misread us, however. We did point out that there is an *association* between infant mortality and physician availability in the rural counties in Indiana and Florida, based on a published work by Allen and Kamradt[2] and an unpublished work by one of us (WLL). As the Madweds must be aware, associations in no way imply cause and effect. In fact, we said, "if these data represent a cause and effect ... then we must insist that family physicians remain involved or become involved in rural and underserved areas."[1]

Any astute observer of maternity care in America understands that the "birthing" of a baby and the "delivery" of a baby are distinctly different processes — by history, philosophy, function, nature, cost, and outcome. We,[3-5] as well as others,[6,7] have more completely discussed these observations.

The Madweds feel that the encouragement of maternity care by family physicians does not need cheerleading. We believe that view can only be held by those who are in protected environments and who have neither seen nor heard about the persecution and pain that many family physicians experience who desire to or try to include maternity care in their practices but cannot. Recent literature has addressed these phenomena further — particularly as they relate to the eastern and southern parts of the United States.[8-10]

To be accused of "not meet[ing] evidence-based standards" when the "imposing ... references" we drew upon, for the most part, fail to do so, is not totally unexpected. But a critical review of these references will show that the majority of evidence-based articles come from "family practice" journals. As so very little of standard obstetric practice has anything to do with evidence-based medicine, we chose not to be too exceptional. Furthermore, we would guess that if the Madweds and most other maternity care providers critically reviewed their practices of maternity care, they would find a variety of beliefs and practices that have no evidence-based substantiation.

We regret the Drs. Madwed are embarrassed by our passion and that somehow enthusiasm is equated with being unscholarly. All science and all scholarly writing done by human beings is by definition subjective. Only those who have no real grasp of the philosophy of science or of epistemology could be taken in by the illusion of objectivity.

Skepticism has its place, but it should not blind us to the experience of truth.

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J.L. Reynolds, MD, MSc
London, Ontario

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To the Editor: The article by Larimore and Reynolds[1] nicely describes and summarizes the literature on family practice obstetrics and makes a reasonable case for continuing and enhancing obstetrics training. There are two interrelated, important issues that they do not address.

First, in the United States there is not an organized system of delivering obstetric care — there are multiple options, providers, and resources. Often, there is a lack of all of these factors in delivering obstetric care. The maintenance of obstetrics as an integral part of family practice must be addressed, clinically, politically, and economically in conjunction with our systems of care and health care reform.

Second, given the family physicians who do obstetrics, what is the guarantee to the population they serve that such services will be offered for a reasonable number of years? There is plenty of anecdotal evidence of burnout and arbitrary withdrawal of obstetric services after a few years of practice — a problem that is particularly acute in small towns and rural areas — that is neither fair to the community nor good for the specialty.

My view is that family practice cannot promote its obstetric tradition and future unless the specialty proposes or participates in developing a system of obstetric services that would be maintained for the community without total reliance on individual provider decisions of whether to practice obstetrics. This implies a much more organized and collaborative relationship with midwives and obstetricians.

Thus, it is unfortunate that the authors do not offer ideas, strategies, or concepts to address the national issue of obstetric care. Under the rubric of women's health, family practice should be proactive at regional and national levels in developing such ideas and how these ideas will relate to, for example, managed care.

Peter Curtis, MD
Chapel Hill, NC

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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.

The above letter was referred to the authors of the article in question, who offer the following reply:

To the Editor: We appreciate Professor Curtis's kind comments about our observations[1] and the two important points he raises in his letter. His first point, that the maintenance and promotion of maternity care are foundational and integral to family practice, is crucial. We have discussed this in the past[2-5] and believe that "family medicine without birthing is not family medicine — it's just medicine."[6] We also concur that the promotion of maternity care in family medicine should be addressed clinically, politically, and economically. However, given that in the United States there is such a diversity of care providers, health and medical systems, and medical and political special interests, it will be very difficult indeed to address these problems in any systematic way.

Nevertheless, until family medicine as an academic discipline commits itself to the provision and role modeling of care during pregnancy and childbirth by family physicians, the first step in solving these problems will never be reached. A clear and consistent message from within our specialty is a critical and unresolved issue that we attempted to address within our paper. We have commented also about this elsewhere.[5,7-9] We agree with those who believe that family medicine's failure to role model adequately this strategic area of family practice is detrimental to family physicians and the patients we serve.[4,10-12] In addition, it results in "family practice faculty who have fewer privileges in obstetrics than their residents could obtain in nonteaching hospitals in their future practices,"[13] leads to "lowered expectations and a decreased breadth of care by residents,"[10] and is associated with decreased satisfaction with family practice and reduced practice diversity and income, and might increase malpractice liability risk.[14,15]

Obstetric privileges represent an "acid test" for the civil rights of family physicians in any particular hospital or training program.[10] Too often, departments of obstetrics and gynecology have the right to veto privileges for qualified family physicians.[10,13,16] "When family physicians are both willing and trained to provide obstetric care to meet the critical need of the communities they serve, barriers that are only arbitrary or political must be removed."[13] The requirement that family practice faculty or practitioners must request obstetric privileges from another specialty, which many believe that family physicians neither can nor should "do OB"[1,17] (and with a large economic interest in the decision[18]), sends the wrong message to our trainees. As Rodney has observed, "Be aware that any specialty that cannot provide its own training and evaluate its own privileges (in its own clinical department of the hospital) has been reproductively sterilized."[10]