The maintenance of obstetrics as an integral part of family practice is particularly acute in small towns and rural areas—that is, services that would be maintained for the community and economically in conjunction with our systems of midwifery and obstetrics.

This poses or participates in developing a system of obstetrics and gynecology that is founded and integral to family practice, is crucial. We have discussed this in the past and believe that "family medicine without birthing is not family medicine—it's just medicine." 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. 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. 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," and "lowered expectations and a decreased breadth of care by residents," and is associated with decreased satisfaction with family practice and reduced practice diversity and income, and might increase malpractice liability risk.

Obstetric privileges represent an "acid test" for the civil rights of family physicians in any particular hospital or training program. Too often, departments of obstetrics and gynecology have the right to veto privileges for qualified family physicians. "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." 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" (and with a large economic interest in the decision), 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."