To the Editor: The article by Larimore and Reynoldsnicely 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

References
If and when family medicine achieves the step of universally committing to maternity care, particularly in the eastern and southern regions of the United States, then we can begin to look at further steps in the process that would engage childbearing women, along with other specialty colleagues, in developing systems of care that are responsive to the needs of childbearing women and of individual communities. Unfortunately, many obstetrician-gynecologists in the United States have been resistant to working with family physicians to meet the needs of childbearing women and society, even though maternal and fetal health indicators are worsening in the United States.

It is indeed a tragedy that family practice residencies are producing the largest number of physicians to provide prenatal care, yet only a minority of family physicians provide this care, when there is increasing need for providers.

Professor Curtis’s second point about physician burnout is extremely important. In attempting to resolve this, we need to address issues of patient and physician expectations, to change the environment of maternity care from one that views labor and birth as a “bomb disposal process,” and to teach physicians appropriate self-care. These issues have been discussed in detail by us elsewhere.

In closing, we would like to reiterate one of the central points of our paper, that once we as a discipline have made a clear and consistent commitment to the provision of childbirth care, and then only then can we begin to develop the strategies and concepts to address the local and national issues of maternity care in America.

Walter L. Larimore, MD
Kissimmee, FL
J.L. Reynolds, MD, MSc
London, Ontario

References


18. Kassbere M. Turf war: how FP’s are vying for your patients. OBG Manage 1994; October;45-54.

To the Editor: Drs. Larimore and Reynolds, in their article “Family Practice Maternity Care in America: Ruminations on Reproducing an Endangered Species — Family Physicians Who Deliver Babies” (J Am Board Fam Pract 1994; 7:737-92) address some valid points regarding the future of family practice obstetrics. The reason for the ever-decreasing number of family physicians practicing obstetrics is indeed multifactorial. Ultimately, the quality of family practice obstetrics training must be questioned. Too many family practice programs have abdicated obstetrics training and delegated it to our obstetrician colleagues, who might neither share our low intervention approach nor have any interest in our future. It is no wonder that the majority of new family practice residency graduates are not choosing to do obstetrics; they lack family physician role models to emulate.

Ostensibly, family practice obstetrics should be considered as essential to family practice as medicine or pediatrics. Few family physicians would exclude either from their practice. The American Board of Family Practice requires residents to perform a minimum number of deliveries to graduate; perhaps there should also be a require-