

## References

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*To the Editor:* The article by Larimore and Reynolds<sup>1</sup> 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.

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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<sup>1</sup> 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<sup>2-5</sup> and believe that "family medicine without birthing is not family medicine — it's just medicine."<sup>6</sup> 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.<sup>5,7-9</sup> 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.<sup>4,10-12</sup> 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,"<sup>13</sup> leads to "lowered expectations and a decreased breadth of care by residents,"<sup>10</sup> and is associated with decreased satisfaction with family practice and reduced practice diversity and income, and might increase malpractice liability risk.<sup>14,15</sup>

Obstetric privileges represent an "acid test" for the civil rights of family physicians in any particular hospital or training program.<sup>10</sup> Too often, departments of obstetrics and gynecology have the right to veto privileges for qualified family physicians.<sup>10,13,16</sup> "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."<sup>13</sup> 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"<sup>11,17</sup> (and with a large economic interest in the decision<sup>18</sup>), 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."<sup>10</sup>

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,<sup>13</sup> 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,<sup>1,16-19</sup> even though maternal and fetal health indicators are worsening in the United States.<sup>20</sup> 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."<sup>21</sup>

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.<sup>5,22-24</sup>

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, then and only then can we begin to develop the strategies and concepts to address the local and national issues of maternity care in America.

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*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; 7:478-88) 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-