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,[13] 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,[1,16-19] even though maternal and fetal health indicators are worsening in the United States.[20] 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."[21]

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.[5,22-24]

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-

ment for all family practice educators to be involved in obstetrics teaching. This would ensure that the salient points of family practice obstetrics are taught and provide a pool of family physician role models.

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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 have written in the past,[1] and will in the future,[2] that family practice teaching programs should utilize family practice role models, especially for maternity care. These role models should consist of both family practice faculty with active privileges to deliver babies and community-based family physicians. These role models are especially important when considering that 72 percent of family practice residents plan or hope to practice obstetrics in their future practices.[3] In addition, medical students planning to enter family practice residencies favor by a 10:1 ratio a residency program with a strong pregnancy care experience over a residency program with less emphasis on this training.[4] Nesbitt[5] has said, "If family medicine educators . . . are ambivalent about the role of obstetrics in family medicine and, therefore, fail to be committed fully to converting residents' intentions to practice obstetrics into practice realities, we risk tarnishing the image of the specialty." Sakornbut and Dickinson[6] are the most recent of several investigators who have demonstrated that family physician supervision (by both faculty and community family physicians) of obstetrics training increases the likelihood that graduating residents will practice obstetrics.

Others have commented further on the issue: Weiss[7] has stated, "Family medicine, as a discipline, may have developed to the point that it is no longer appropriate for family physicians to be trained by physicians in other specialties . . . [who] have skills, knowledge, and probability (referral bias) thinking that are often inappropriate when applied by family physicians." Smith[8] has said, "Our [family practice] residents, trained at the hands of our obstetrical colleagues, often perceive pregnancy care as too risky for the family physician." She further comments, "It is long past time for us to stand behind our rhetoric with our action,"[8] especially now that Nesbitt and his colleagues[9] have so elegantly shown us that we can regain much lost ground by reclaiming our role as supervisors and mentors of our residents' maternity care training.

Lastly, we appreciate the comments of Rodney,[10] who has stated:

> Our own family practice representatives within academia have wandered far from the path. In a way, obstetrics represents the "acid test" as to whether or not family physician faculty really practice what they preach. Unfortunately, if we studied family medicine faculty, we would find that many do not practice a wide variety of skills, ranging from EKG interpretation to obstetrics. Obstetrics is simply the visible tip of the iceberg. Multiple studies have shown that a lack of family physician role models actively contributes to lowered expectations and a decreased breadth of care by residents.

Our concern, as expressed in our paper,[11] is that any failure of family medicine to teach and role model appropriate maternity care has many potentially far-reaching and negative effects on our residents as they enter practice; our patients, who cannot locate family practice maternity providers; our society, which needs additional childbirth providers; and our specialty, which cannot be the same if it abandons maternity care. We believe that the failure to provide family practice role models for maternity care in a family practice residency program represents medical education malpractice or, at the very least, malfeasance.

For these reasons, we would agree with Dr. Terry that family practice educators not only should, but must, be involved in maternity care education and would applaud and support the AAFP Obstetrics Task Force and AAFP Congress of Delegate's recommendation to the Residency Review Committee to create a policy demanding the presence of family practice role models actively delivering babies as a criterion for successful accreditation.[12]

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