Obstetric-Enhanced Family Practice Residency Training

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The family medicine literature is replete with articles lamenting the decline in family practice obstetrics.[1–9] While the numbers of all obstetric providers are declining, the drop is greater for family physicians.[4,10] The resulting decline in access to prenatal care is particularly serious among poorer women[11] and those in rural, underserved areas,[10] for whom family physicians provide a disproportionately large share of the care. Yet family physicians are well prepared to provide care for disadvantaged patients, whose high-risk status is often related to social and economic factors. These patients are likely to benefit from an approach that emphasizes sensitivity to patient context (family and community) and provides continuity over a major life cycle transition.

Although obstetricians and gynecologists are often the primary source of care for many women,[12] obstetrics and gynecology training programs provide little preparation for residents to become primary care physicians. According to the Institute of Medicine report on primary care,[13] most obstetricians and gynecologists do not provide primary care, a view supported by other studies.[14] Training often tends to be technically oriented rather than humanistic, to encourage a physician-centered perspective, and to model a paternalistic physician-patient relationship. Family medicine, in contrast, has emphasized a more humanistic, patient-centered, and biopsychosocial orientation that encourages sensitivity to the patient in her social and family context. This systems approach supports the empowerment of female patients and is congruent with the recently released report of the Public Health Service Expert Panel on the content of prenatal care.[15,16]

Despite the need for obstetric providers and despite the strengths of the family medicine orientation to address this need, the delivery of prenatal care by family physicians is declining. There may be many reasons for this decline and the consequent crisis in access. Those usually cited include malpractice concerns,[3,5–9,17,18] lack of good family physician obstetric role models,[2,3] inadequate training,[3,6,8,9] and lifestyle concerns or time constraints.[3,5,6,8,9] Some solutions have been proposed and implemented. There is evidence that tort reform has to some extent stemmed the decline.[19] Subsidized prenatal care programs involving family physicians have been effective in increasing access to care for poor, rural low-risk women.[20] Rosenblatt[4] has proposed a solution based on the premise that family physicians are trained primarily to manage low-risk deliveries. He suggests that "obstetric referral centers" be abandoned and an alliance forged with nurse midwives. Although this solution is predictably controversial[21,22] in the United States, a working model has been successfully implemented for 10 years in Spokane, Washington.[23] This approach, however, addresses only low-risk patients. There is evidence that with an appropriately supportive system, family physicians can successfully manage higher risk patients.[24]

Clearly, multiple avenues to address these problems need to be explored. As one solution, a family medicine residency track with enhanced obstetric training is proposed. The American Board of Obstetrics and Gynecology requires a minimum of 18 months of obstetrics to prepare for the obstetric component of board certification. Eighteen months also corresponds to the typical experience of graduates of family medicine obstetric fellowships (6 months during residency and 1 postresidency year). The additional obstetrics experience could be accommodated within a 3-year family medicine residency by modifying some of the other requirements. The increased time spent on obstetrics would enable residents to enhance their technical skills so that they could practice a range of obstetrics comparable to obstetricians and gynecologists. In other areas, the psychosocial[25] and community medicine curricula could emphasize relevant issues such as access, single parenting, and child development.

Graduates from obstetric-enhanced family practice pro-

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grams could provide comprehensive family-centered care to high-risk patients particularly in rural and urban inner-city areas. There is a significant demand for such training from medical students as an alternative to traditional obstetrics and gynecology residencies, which have little psychosocial training or opportunity for providing continuity care. With increasing numbers of women entering medicine,[26,27] we anticipate that this demand will increase. Because of its orientation and history, family medicine is uniquely qualified to develop this option.

A number of concerns are likely to be raised by this proposal. First, it would result in fragmentation of the specialty. This argument, however, is largely rhetorical. In practice, family practice already includes a wide range of practice patterns. Family physicians either do obstetrics, shifting their practice toward obstetrics and pediatric and women's health care, or do not do obstetrics, shifting their practice toward adult and geriatric medicine.[28,29] Increasing obstetric training would simply better prepare family physician graduates for managing patients with a broader spectrum of obstetric risk. A more important fundamental issue is determining the essential elements that define family medicine as a specialty. The specialty is not simply a balance between the different clinical content areas; rather, it is the systems approach to health care. This approach integrates the role of the physician, the biopsychosocial context of the patient, and their relationship. Under this rubric, the proposed obstetric-enhanced residency training program is truly family practice.

A second concern may be that the training currently obtained by family practice residents would be devalued. Developing a cadre of family physicians more highly skilled in obstetrics, however, could provide support for other family physicians. During training these residents are likely to be more supportive of their family physician peers than residents in traditional obstetrics and gynecology programs. Graduates from obstetric-enhanced training programs could also serve as clinical faculty in other training programs to support family physician training in obstetrics. Finally, when in practice these graduates would be well placed to provide responsive obstetric backup to their family physician colleagues.

A final concern is that graduates of an obstetric-enhanced training program would be isolated, without role models, committed to practicing obstetrics with few options for alternative practice or relief from call responsibilities. This problem is likely to arise, at least initially, particularly for graduates in isolated rural areas. Nevertheless, just as family medicine in its infancy attracted independent-minded pioneers, so this option would attract a new generation of social activists among today's medical students who will be temperamentally suited to deal with the challenges.

This proposal will not solve all of the needs for biopsychosocially sensitive care for women and young families or completely address the decline in the role that family physicians play in obstetric care. Rather, the proposal is intended as an option that has the potential to address some aspects of these problems. As one response to the two pregnancy care crises of access and declining participation by family physicians, this option should be carefully developed and implemented.

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