EDITORIAL

Family Medicine Obstetrics: Answering the Call

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It continues to be more dangerous to be pregnant and deliver a baby in the United States than in any other high-income country.[1] Severe maternal morbidity and mortality is even higher for those who identify as Black and those who live in rural areas. Policy statements from the AAFP[2] and the White House Blueprint for Addressing the Maternal Health Crisis[3] call for expanding and diversifying the perinatal workforce, including ensuring family physicians are trained to provide critical pregnancy care, particularly in rural and underserved communities.

This issue of *Annals* includes a study[4] that expands our understanding of the positive impact that family physicians bring to improving perinatal health quality, particularly in rural hospitals. It highlights the value of family medicine in an often underrecognized gap that is being filled by the primary care workforce. The paper adds to the robust existing literature that finds clinical outcomes and care delivered by family physicians is on par with specialists.[5-8] It expands this work by examining the potential impact family physicians can have on the safety culture of the obstetrical care team. A main finding of this study is that nurses on labor and delivery units had a more favorable attitude about the safety culture and practices that support lower cesarean section rates in hospitals where family medicine physicians provided labor and delivery care. To explain this, the authors theorize that family medicine training that emphasizes relationship building, continuity of care, and shared decision making impacts interpersonal communication and team-based care in practice settings.

Family medicine residencies have a strong culture of centering training in interprofessional teams with formal teaching and feedback in communication and teamwork integrated into the core training experiences. Family medicine training frequently includes completion of the AAFP's Advanced Life Support in Obstetrics (ALSO) course.[9] This course is utilized by many family medicine residency training programs and other practice groups to improve teamwork and skills in handling obstetric emergencies. In addition to providing clinicians with hands on skills to handle common obstetrical emergencies like shoulder dystocia and postpartum hemorrhage, a central theme in ALSO is developing evidence-based communication and teamwork skills. In addition to ALSO and other pregnancy care safety courses, formal and informal training in team-based care is a key required component for all family medicine programs. The American Board of Family Medicine (ABFM) core outcomes for all family medicine graduates include that each graduate must be competent to "Effectively lead, manage, and participate in teams that provide care and improve outcomes for the diverse populations and communities they serve."[10] The results of the study in Iowa support the hypothesis that this training supports family physicians in their role improving patient outcomes in intrapartum care and creating a safety culture in interprofessional teams.

We agree with VanGompel et al that "the unique talents of its [family medicine] graduates, in patient- and family-centered care, teamwork, and communication, are most needed to solve a growing maternal health crisis." Unfortunately, only 12% of recent family medicine graduates are delivering babies in their practice.[11] This number has been decreasing over the decades despite Accreditation Council for Graduate Medical Education (ACGME) and ABFM requirements stating that residents must graduate competent to "perform a vaginal delivery." To ensure that family medicine residents training in our current environment have clear expectations for competence in the ambulatory and intrapartum aspects of pregnancy and obstetrical care, the ACGME made changes to maternity care training in 2023. The requirements for training to competency in intrapartum care increased the required number of deliveries in training to 80 and the time on labor and delivery during training to 4 months.[12] This volume of training is supported by evidence that it is associated

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with more graduates performing deliveries in practice.[13] The authors expressed concerns around these changes and their long-term effects. Our specialty will need to monitor this over time to see if improved transparency helps to support family physicians continuing to provide pregnancy care across the entire spectrum of care.

Like any aspect of medical training, clinical and skill competence cannot be achieved in a vacuum. Maternity care in antenatal, intrapartum, and postpartum settings now requires greater collaboration with a wider range of clinical domains including cardiovascular health, mental health, addiction medicine, and maternal fetal medicine. Innovative GME curricula that support interprofessional training experiences in these areas will be essential to sustain future obstetrical practice by family physicians working in urban underserved and rural settings. In 2021, the Health Resources and Services Administration (HRSA) launched the Primary Care Training Enhancement—Community Prevention and Maternal Health (PCTE-CPMH) program which has funded 31 family and preventive medicine residency programs to improve the number of primary care physicians trained in enhanced obstetrical care in rural and/or underserved areas.[14] These demonstration projects may provide blueprints for ongoing best practices for addressing the drivers of maternal morbidity and mortality across many inpatient and outpatient perinatal settings. By creating interprofessional training opportunities, integrating residents into FQHC and rural health settings and expanding scope and mentoring capacity, the family medicine workforce may be even more prepared in the future.[15] In one of our large academic tertiary care sites for example, family medicine offers consultation to all pregnant and postpartum patients with substance use disorder admitted to any of the obstetric or maternal-fetal medicine services and can provide ongoing outpatient care for those families.

The findings by VanGompel et al suggest that family medicine presence in labor and delivery adds significant value to the safety culture while also providing at least equivalent care in a key maternal health outcome. While the exact mechanism will remain a question, with so many identified gaps in maternal health related to the need for primary care, behavioral health and addiction medicine, it would make sense that enhancing the presence of family medicine on labor and delivery units can be a key strategy to improving patient centered care and maternal health outcomes.

With alarming rates of hospital and labor and delivery unit closures in many rural communities and projected shortages of all obstetrical providers over the next decade, health leaders must take action to ensure that families have access to comprehensive pregnancy care. Reducing barriers to inclusion of obstetrical practice for family medicine physicians with competency in this area should be a priority for departments of health, health systems and hospitals in all settings.

As we asked during the Starfield IV Summit: "What does society need from family medicine?" Right now, society needs comprehensive pregnancy/maternity care that integrates across the lifespan, can span multiple health care settings, and is provided by high functioning interprofessional teams that put the patient at the center of care. Our current system isolates care during pregnancy and postpartum periods into silos of care that do not always integrate well with the rest of the healthcare system. Family physicians are uniquely trained to help lead interprofessional pregnancy care teams that promote a safety culture and improve health outcomes. As we design new training models to promote this vision, we need to not only focus on patient care skills in pregnancy care but also the critical skills for leading and being included in interprofessional teams needed to provide comprehensive pregnancy care.

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Key words: family medicine; cesarean birth; obstetric teams; perinatal health quality; relationship building; continuity of care; shared decision making

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