

Essays and Commentaries

Why Pregnancy Care Should Be an Essential Part of Family Medicine Training

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Some family medicine educators are arguing to eliminate pregnancy care as a required component of family medicine training since the majority of family physicians no longer perform deliveries, and many programs are having increasing difficulties in meeting this training requirement. The primary benefit of pregnancy care training is not to produce family physicians who all perform deliveries but to produce family physicians who are competent to provide comprehensive primary care to women and girls, including routine and preventive reproductive care. The training in pregnancy care helps to differentiate family medicine residencies from other primary care training programs by facilitating competency in a wide range of reproductive health care for nonpregnant women and for the primary nonreproductive health care of pregnant and postpartum women. Residencies offering pregnancy care services also enhance their ability to train residents in child care. Family medicine should continue to strive to improve this aspect of residency training instead of abandoning it.

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Let me start off by saying that I deliver babies and love it. I almost went into obstetrics and gynecology as a medical student because of that, but then I realized that I also enjoy taking care of adult men and women as they move through the different stages of life. I loved to take care of their children and not continuing to care for that baby after it left its mother's womb seemed unnatural to me. I should also note that I realized that obstetricians were surgeons, and I knew I was not a surgeon, so I followed my dream and my original plan and I became a family physician.

I begin with this personal disclaimer because I know that most of those who argue that pregnancy care should not be part of the core "basket of clinical services" in family medicine see those of us who do

deliver babies as trying to forcibly push all family physicians back to the delivery room. That is not what I am arguing. My core argument is that if family medicine removes deliveries from its core training, then family physicians will no longer be able to provide comprehensive primary care for women and thus for families. Further, this move will mean that women can no longer have a physician with a medical specialty who is trained to provide them comprehensive primary and preventive health care. This would truly be a step backward for women's health and the movement toward gender equity in the provision of health care.

Tiemstra recently wrote a commentary in this journal that argued that one of the ways to "fix" family medicine training would be to eliminate pregnancy care as a requirement of training.¹ His arguments concentrated around the obstacles that many programs face in meeting current accreditation

guidelines in pregnancy care and around resident and student disinterest in performing deliveries. He argued that pregnancy care training should be optional and experiences concentrated for residents and programs that decide to "specialize" in this area. He argues that we need to be responsive to the current trends in medical student interest in more "lifestyle friendly" specialties and to the current difficulties many programs are having maintaining pregnancy care practices.

The problem with this approach comes if most programs slowly phase out pregnancy care training entirely because of the difficulties he noted. At that point, the basket of clinical services offered by physicians trained in the "new" family medicine programs will become less distinct or perhaps indistinguishable from those trained in combined internal medicine and pediatric programs. Despite a recent trend of internal medicine programs requiring some training in outpa-

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tient gynecology, it is my experience that most internists are still uncomfortable providing routine reproductive health services such as pap smears, bi-annual exams, and contraception. Their female patients are often required to see two physicians to receive routine preventive health care. In my practice, many women are pleasantly surprised when I inform them during their annual visit that they do not need to see a gynecologist, because I am fully able to include their breast and pelvic exam with a pap smear as part of their physical, to provide them with their birth control pills, and to even deliver their babies.

Family medicine is currently the only specialty in the United States trained to provide comprehensive primary and preventive health care for women. It is a statement of medicine's continued gender bias that for other primary care specialties (internal medicine and pediatrics), women and girls must go to a "specialist" to have routine and preventive health care for their reproductive organs. This is not the case for men, who do not routinely see urologists for prostate exams or if they develop a sexually transmitted disease. Given that pregnancy is a common condition for women, family physicians should be trained to care for women during this time.

I understand that for lifestyle and personal practice preferences, many family physicians do not want to perform deliveries, just as I understand that there are many family physicians who do not care for patients in an intensive care unit (or sometimes in the hospital at all). But I do not see many people arguing that these aspects of care should be excluded from the required training of all family physicians or be considered part of our core basket of clinical services. Hospital, intensive care unit, and delivery room training all provide physicians in training with core experiences to see the ultimate outcome of the ailments we care for in the outpatient

setting. Requiring some basic competencies in intrapartum care enhances residents' opportunities to achieve higher competency in office-based reproductive health and pregnancy issues. By caring for pregnant patients as residents, family physicians are more comfortable with gynecologic exams, female reproductive anatomy, and routine prenatal and postpartum care and are more competent to handle routine medical issues that arise in pregnant and postpartum women.

In addition to our loss in reproductive health skills, the elimination of pregnancy care as a core training experience would also decrease residents' experience with care of children. A recent study documented that family physicians are seeing a smaller proportion of children's office visits in the United States than they did in the past.² A hypothesis for this shift in health services is that over the same time period, fewer family physicians provided prenatal care and delivery services and, therefore, fewer infants entered their practices. I have found this to be true in my own anecdotal experience, where I have observed that family medicine residency faculty who do not include pregnancy care in their practice (this can mean prenatal care only or both prenatal care and deliveries) seldom cared for young children and often had practices with demographics that resembled that of an internist.

From a public health standpoint, the loss of family physicians trained in pregnancy care will decrease access to prenatal care and delivery services within many rural and underserved communities. Studies show that family physicians provide a large proportion of the pregnancy care to underserved populations and in some communities are the only providers, since the communities are not large enough to support an obstetrician.³ Particularly in an environment where many OB-GYN specialists are choosing to stop performing deliveries, there is an ever-

growing need for family physicians to continue to provide this essential service.

Finally, we should remember that pregnancy care is not just about deliveries. While only about 30% of family physicians provide intrapartum care (deliveries), many more provide prenatal and/or postpartum care. There is currently no published national data describing the percentage of family physicians who provide prenatal and/or postpartum care, but a recent Canadian study reported that while only 16% of Canadian family physicians provide intrapartum care, more than 50% provide prenatal and/or postpartum care.⁴ These services, as suggested for the New Model of Family Medicine, should remain in the core basket of clinical services because pregnancy is definitely within the category of common and routine conditions seen in family medicine. Indeed, more women experience pregnancy in their lifetimes than experience hypertension. To provide quality prenatal and postpartum care, family physicians must have exposure and training in intrapartum care to serve as a reference for future prenatal and postpartum care. This is analogous to the need for training in an intensive care setting to provide high-quality care in the less acute inpatient hospital setting.

In summary, I am concerned about the growing voices within family medicine that are arguing for the removal of pregnancy care as a required component of residency training. Pregnancy care is an essential part of what makes family physicians distinct from other primary care specialties and allows us to play a unique role in the US health care system as the only comprehensive primary care specialty for the care of women and girls. The primary benefit of pregnancy care training is not only to produce family physicians who routinely deliver babies but also to produce family physicians who are competent to

care for the entire woman and her family in all aspects of her life, thus ameliorating the gender bias that continues to exist in medicine.

We should not give up this part of our identity or water it down because it is difficult to achieve. Instead we should celebrate it and strive to continue improving this vital aspect of our training programs.

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