

LETTERS TO THE EDITOR

In Response to “The Impact of Practicing Obstetrics on Burnout Among Early-Career Family Physicians”

TO THE EDITOR:

Thanks to Dr Tyler Barreto and colleagues for writing “The Impact of Practicing Obstetrics on Burnout Among Early-Career Family Physicians” in the June 2020 issue of *Family Medicine*. Their article thoughtfully outlines the family medicine-obstetric paradox wherein delivering babies can simultaneously protect from and contribute to burnout for family physicians. While unpredictable call hours and fear/stress of patient outcomes can contribute to provider stress, conversely, delivering babies brings joy to the practice, diversity in practice, and “keeps the practice young”¹

As an early-career family physician myself, these are the reasons I choose to incorporate family-centered maternity care in my full scope practice. I believe the positives of delivering babies certainly outweigh the negatives. In the original article, family physicians commented on the lifestyle aspect of delivering babies (unpredictable long hours). Balance can be reestablished with a structured schedule. OB night call followed by an administrative morning, instead of patient care, can be protective for the physician to get a later start to the day if it was a busy night. Fear and stress of complicated patient outcomes can be reduced by having adequate OB backup coverage. A laborist model, as practiced at my hospital, is one example. Having a 24-hour OB laborist available in house to help with obstetric complications helps young family physicians feel less fearful of bad outcomes, leading to less burnout.

Additionally, having more family physicians practicing family-centered maternity care will stage a strong model for residents in training. As noted by Dr Chen, maternity and obstetric care is, and must always be, a central pillar of family medicine training. The pregnancy and birth experience is a foundational element of our scope as family physicians. Maternity care directly grows and supports our pediatric care. It also teaches us procedural skills and familiarity. Most importantly, it ties us to the broad

scope of care for women, children, and families. It cannot be diluted or lost.²

From a practical standpoint, obstetrics also ensures young children in the practice. This is essential to meeting ACGME-required pediatric numbers, which can generally be challenging for family medicine residencies. There are aspects of delivering babies and providing family-centered maternity care that can lead to physician burnout, however with schedule modification and having adequate OB backup coverage, we can take better care of ourselves, while offering a full-scope practice.

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Authors' Response

TO THE EDITOR:

We thank Dr Kadia for her positive review of our work, and we appreciate her willingness to share personal experiences that add to the 56 interviews included in our study. Our study described ways that providing obstetric care both contributes to and prevents burnout. We identified three ways that providing obstetric care contributes to burnout for family physicians: stress/fear factor, time commitment, and OB call schedule. We agree that one way to minimize stress/fear factor could be to have OB backup coverage available, and that one way to minimize time commitment and OB call schedule concerns could be to have a structured call schedule. We were happy to hear that these solutions are working for Dr Kadia.

It is important to note that OB backup coverage and a structured call schedule may be a privilege of working in urban and/or academic practice settings. Though some of the physicians who participated in our study described

being supported through those strategies, others did not. We recognize that different clinical settings may produce different burdens related to providing obstetric care as family physicians. Regardless of practice setting, it is possible that an adequate call structure could be the key to eliminating the paradox and protecting family physicians who want to deliver babies from burnout. However, recognizing the variety of settings in which family physicians work, we advocate for finding creative solutions to address burnout for physicians in settings where OB backup coverage and structured call schedules are not a realistic option. doi: 10.22454/FamMed.2021.560051

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Time for Social Justice: One Residency Program's Response to a Call for Action

TO THE EDITOR:

Three years ago, when we began our family medicine residency, we aspired to become physicians who are not only adept at managing our patients' chronic medical conditions but also serve as their advocates. We chose family medicine because of the emphasis that it places on incorporating social determinants of health into chronic disease management and feel proud to be training to care for patients as their primary care doctors.

The last several months of our residency, however, were upended by the COVID-19 pandemic and further exacerbated by persistent police brutality and racism that led to the most recent series of protests in our city of Philadelphia. Both of these situations further exposed the inequities that impact the well-being of our patients. This acute and chronic trauma that communities of color disproportionately experience is just as much a determinant of health as food and housing insecurity.

In Philadelphia, where we trained and intend to practice, most people identify as People of Color: 42% of Philadelphians identify as African-American, 14.5% as Hispanic or Latino, and 7% as Asian. We see this diversity in our patient population both at our residency practice and at community sites where we trained. Despite this, when we reflect upon our

training, there is a noticeable void of antiracist introspection, dialogue, and action.

With such unequivocal evidence that police brutality and this pandemic disproportionately affect the patients we serve, we feel it is our responsibility to initiate conversations with our colleagues and our patients to address this structural violence. In response to STFM President Tricia Elliott's call to action,¹ we proposed a number of structural changes to our program, which follow. As suggested by Guh and colleagues,² we believe that these interventions will need to target multiple aspects of our residency to lead to significant and lasting changes.

- Drawing from the work of Wu et al³ incorporating antioppression curriculum through quarterly workshops focused on developing skills for allyship into resident didactics
- Training residents to be competent in screening for structural and social determinants of health, including police brutality and other forms of structural racism
- Prioritizing recruitment and retainment of underrepresented minority residents and faculty members similar to the successful efforts of Boston Medical College as published by Wusu et al⁴
- Ensuring that time and resources from our department and program are allocated to community organizations to better understand and address our patients' needs

We presented these proposals to our residency and feel proud to be members of a department where we are having these conversations and making changes to more explicitly address racism in health care. Despite all of the darkness that the pandemic and police brutality have exposed, we hope this serves as an impetus for other residents to ask of our colleagues, mentors, programs, and academic societies to work toward equity in medicine, starting with the education and diversification of residency programs.

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Be the Change

Be the change that you wish to see in the world.
—Mahatma Gandhi

TO THE EDITOR:

As the family of family medicine, we are here for such a time as this. During this unprecedented year, I have had multiple conversations about the continued tragic displays of racial injustice and police brutality, including conversations with resident physicians and students who seek to be proactive, not reactive, and engaged leaders in the process of meaningful antiracism change. I applaud Drs Ehrman-Dupre and Moyer for answering the call to action and taking the lead in their program and community to dismantle structural racism, drive social justice, and advance equity. They have provided a model that can inspire others to action in residency programs and departments across the country. The key word is “action.” Inaction and silence are no longer an option.

The actions proposed are an impressive framework for others to follow and build upon: building social justice/antioppression curriculum; providing education and training for residents to incorporate patient screenings centered on social determinants of health and racism in the exam room; prioritizing underrepresented in medicine (URM) recruitment of faculty and residents; and building partnerships with community organizations engaged in addressing these efforts. I am eager to see their progress as they measure their goals and objectives and look forward to continued dissemination. I urge us all to follow the authors’ lead in our own programs, departments, and communities and to “be the change.” Thank you, Drs Ehrman-Dupre and Moyer.
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Workplace Communication in the Midst of COVID-19: Making Sense of Uncertainty, Preparing for the Future

TO THE EDITOR:

Life in the time of COVID-19 is like being dropped suddenly into an unfamiliar country without the benefit of a smiling tour guide. Everything in this country seems at once disorienting and exhilarating. It is challenging to understand even the most basic cultural norms. People are emotionally exhausted, constantly trying to navigate between remembrances of times past and hopes for the future.

COVID-19 has significantly altered our sense of normal, especially in regard to our workplace routines and relationships with colleagues. For example, one of our residents experienced recurring problems connecting to patients via televideo. She consulted with Information Technology, who said they could help (but it would take time). Fortuitously, she later shared this with the chief resident, who noted that other residents had already moved to a different televideo platform because of similar problems. Absent regular informal channels for sharing information, the resident was unaware of this change.

This glitch and its work-around would previously have been discovered serendipitously before or after educational meetings. While our virtual reality has introduced novel ways to connect,¹ it has simultaneously closed the door to traditional opportunities for communicating important information.

How do we deal with this? We recommend that organizations use five “As” to plot a course in this new world:

1. **Be Aware:** Open our eyes, ears, and minds to how things are changing and what we are losing in the process. Suspend attachment to usual ways of doing business and our native environment that has been routinely comfortable.
2. **Acknowledge Losses.** Openly state what has changed and what is missing. Acknowledge the emotions swirling around those changes, including discomfort and anxiety.
3. **Develop Alternatives.** Brainstorm options for moving forward. Use the skills of adaptive expertise to see with new eyes and try out potential responses to uniquely stressful situations.²

4. **Adapt.** Be willing to fail. Plan-do-study-act (PDSA) cycles and other quality improvement initiatives use circularity to advance.^{3,4} They do so by identifying changes that do not work as well as those that do.
5. **Anticipate the Future.** COVID-19 will not automatically lead to a new established order. We need to develop process-oriented ways to address multiple new realities that have emerged from the vicissitudes brought on by the pandemic. We need to develop workplace cultures that embrace ongoing transformation in light of shifting situational factors.

The environment in which we are now working does not support us in the ways the previous one did. We must state our losses, minimize our denial responses, suspend our attachments to old ways of doing business, be creative, and seek out new and not-yet-recognized paths forward. As we design and implement these new paths, we must acknowledge that some will lead to dead ends. We must see ourselves as courageous explorers, embarking on new and uncharted seas to discover. Throughout, we need to maintain the core relational tenets of our specialty,⁵ values that have consistently helped family physicians be the masters of healing in the face of uncertainty. doi: 10.22454/FamMed.2021.216908

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PRISMA Systematic Review Protocol Essential for Valid, Actionable Results

TO THE EDITOR:

Dr Kerrigan et al's article "What Barriers Exist in the Minds of Vaccine-Hesitant Parents, and How Can We Address Them?"¹ covers a topic of critical importance. The authors state that their aim was to "systematically analyze available literature," but their methodology did not adhere to the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses)² standards of a systematic review. If the authors' intent was to rigorously answer this clinical question, following standard systematic review protocol would have increased the accuracy of their findings.

Dr Kerrigan et al did not specifically state that they conducted a systematic review in their title or article, but the statement "systematically analyze" in their abstract, in conjunction with a PRISMA flow diagram,³ suggests their overall goal was similar. If their intent was to conduct a comprehensive search of available literature to answer their question, following systematic review methodology would have best accomplished that task. A systematic review "attempts to identify, appraise and synthesize all the empirical evidence that meets prespecified eligibility criteria to answer a specific research question."⁴ Performing a systematic review requires adherence to "explicit, systematic methods that are selected with a view aimed at minimizing bias, to produce more reliable findings to inform decision making."⁴ They did not search all available literature, as they only examined one database with four search terms. They did not outline strict inclusion and exclusion criteria for the studies they reviewed. They did not present a bias assessment of included studies. They did not include a table describing each of the included studies' design, specific vaccine, participant population, study size, methods, and findings. Table 1's questions for data extraction are not precise enough to inform a rigorous summation of their findings. In addition, they ranked the reasons for vaccine hesitancy according to the number of articles that cited the reason; the number of articles does not necessarily equate to evidence quality. By not following established systematic review methods,⁵ the validity of their results is questionable.

As we weather the first great pandemic of the 21st century, best practices to encourage

vaccination are more important than ever. If the authors had chosen to follow established systematic review guidelines, readers might be more willing to implement their article's recommendations. Conducting a lengthy cohort study of patients with varied vaccination status, as the authors recommend, could also delay needed change. The Centers for Disease Control and Prevention, the American Academy of Family Physicians, and the American Academy of Pediatrics⁶ instead encourage clinicians to use quality improvement to increase immunization rates. Quality improvement initiatives can more quickly lead to necessary change to achieve health equity in vaccination. doi: 10.22454/FamMed.2021.665422

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