— What Should We Teach? —

Women Deserve Comprehensive Primary Care:

The Case for Maternity Care Training in Family Medicine

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Fifteen years ago, I was a young, passionate family physician starting my first faculty job in a residency program in Manhattan where I was going to train residents to deliver babies. I wrote "Why Pregnancy Care Should be an Essential Part of Family Medicine Training"[1] during my orientation. What I wrote then still stands now:

- Some in family medicine are advocating to eliminate maternity care as a family medicine requirement due to the decline in family physicians performing deliveries and the increasing difficulties for programs to meet training requirements.
- The primary benefit of maternity care training for all family medicine residents is to produce family physicians who can provide comprehensive primary care to patients of all genders across the life spectrum.
- Training in maternity care helps to differentiate family medicine from other primary care specialties.

While working in Manhattan, I came to the realization that many people in New York City desperately needed access to high-quality, patient-centered maternity care and that those services could best be provided by family physicians working at federally-qualified health centers (FQHCs). Over the years, several residents who matched to our program ended up wanting to be trained to deliver comprehensive maternity care despite their original intentions. Now, I work at my residency alma mater: a Massachusetts FQHC that serves the needs of a community with no historical access to prenatal care until they developed their own family medicine maternity practice. Despite training in an urban setting only 25 miles from Boston, over 60% of our graduates deliver babies as part of their practice. Despite these examples of family physicians wanting to deliver high-quality, high-touch maternity care to their communities, there continues to be a decline in maternity care provision and other reproductive health services by family physicians across the United States.

What Does Society Need From Family Medicine?

Our health care system is dysfunctional and inefficient and provides poor outcomes that are worse for women, rural Americans, and people of color. Nearly half of the counties in the United States have no obstetrician-gynecologist, leaving rural and urban underserved communities with no services (Figure 1). The United States has rising maternal mortality, which disproportionately affects rural and Black, indigenous, and people of color (BIPOC), patients. Much of this increase in maternal mortality stems from underlying physical and mental health conditions as well as structural issues including food insecurity, housing, transportation, racism, and lack of access to health care. Considering these disparities, we

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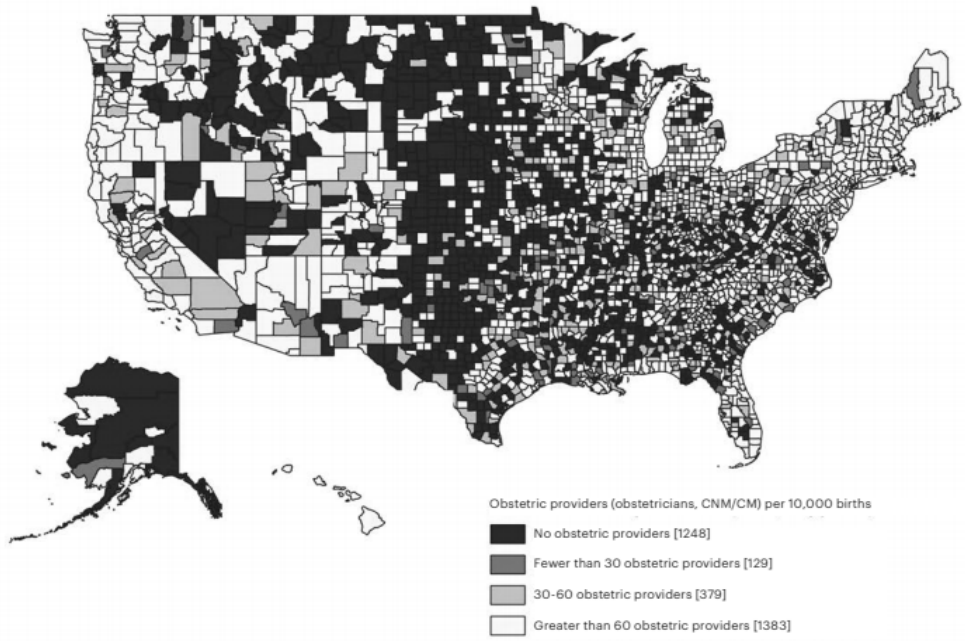
Figure 1: Distribution of Obstetric Providers (Ob-Gyn and CNM) by US County, 2017



Abbreviations: Ob-Gyn, obstetrician-gynecologist; CNM, certified nurse midwife.

Source: March of Dimes Maternity Care Desert Report, 2020: https://www.marchofdimes.org/materials/2020-Maternity-Care-Report.pdf.

must ask ourselves, "who provides primary care for women?" Comprehensive primary care for women requires a physician who can care for women's most common health needs, which includes family planning, preventive health care for cancer and cardiovascular diseases, and perinatal health care. Ideally this includes the care of children as well, as many women (especially women of color) will seek care for their children rather than themselves.[2] Family medicine is poised to provide comprehensive primary care to all women and their children.

What Should We Teach and How Should We Teach It?

While many within our specialty can agree on the societal need for more family physicians to be providing comprehensive primary care for women, many program directors face structural barriers within their institutions and communities to providing the necessary training. These challenges are real, but in order to improve the health outcomes of our communities, we need to push our institutions to be part of the solution, and training regulations are a critical tool to do this.

The crux of the controversy is that programs struggle with patient and procedure volumes and with finding faculty to teach residents these skills. After the adoption of the 2014 ACGME Family Medicine Requirements (which eliminated targeted numbers of deliveries), there has been a 22% decline in deliveries performed by family medicine residents. Based on several studies,[2-4] the following factors are associated with graduates including maternity care in their practices and should guide our approach to creation of evidence-based requirements:

- Caring for prenatal patients in continuity during training;
- Significant labor and delivery experience;
  - Residents with more than 80 deliveries during training were significantly more likely to be performing deliveries in practice; and
- Family medicine role models training residents in maternity and newborn care.

Recommendations for ACGME Requirements

The ACGME defines the floor for the minimum training that residency programs must provide, while the American Board of Family Medicine (ABFM) defines the minimal training required for individual physicians to be board certified. The idea of one minimum for the purposes of ACGME accreditation has been a barrier to the tiered training idea that has been promoted in the specialty[3] and reflects

somewhat the current reality. Unless the ACGME is willing to provide flexible guidelines that reflect the current uneven need for comprehensive maternity care training, we will need to use variable pathways for focused practice recognition with the ABFM[5] to provide realistic training requirements for residents that will guide programs and health systems to trust in the competency of our graduates. Figure 2 gives my recommended language to the ACGME for new maternity care training requirements. Since maternity care is an essential component of women's health, these recommendations reflect this, but also attempt to strike a balance with the reality of regional variations and emphasize training that enhances the care for all women, even if deliveries are not incorporated into future practice. I recommend minimum requirements for all programs that focus on attaining competences to care for all women in the outpatient setting, and additional requirements for enhanced training for competency in intrapartum care and surgical maternity care that would be recognized by the ABFM with focused practice recognitions. All programs have a minimum

Figure 2: Recommended ACGME Maternity Care Requirements

All residents must be competent to care for women who are pregnant including obtaining the following competencies:

- Diagnose pregnancy and manage early pregnancy loss including diagnosis of ectopic pregnancy, and options counseling.
- Low-risk prenatal care
- Care of common primary care conditions during pregnancy
- Postpartum care including screening and treatment for postpartum depression, breastfeeding support, and family planning

All residents must have documented attainment of the above competencies including completion of the following clinical experiences:

- Complete two months (or 200 hours) of training on labor and delivery. During these rotations residents must:
    - Be involved in the labor management and perform at least 25 deliveries during this time (Core)
    - Care for postpartum women (Core) including care for mother-baby pairs (detail)
- Care for pregnant women in the outpatient setting (core) with at least 150 encounters
    - Must include routine prenatal care (core) including care of the same pregnant woman over time (detail)
- Care for postpartum women in the outpatient setting (core) with at least 15 encounters

All family medicine residencies are required to have at least one faculty member with privileges to provide intrapartum and newborn care in a hospital or birthing facility (Core).

Residents who plan to have the option to incorporate intrapartum maternity care and vaginal deliveries (and related procedures) must complete the following additional training:

- Complete at least four months (or 400 hours) of training on labor and delivery and perform or directly supervise at least 80 deliveries (with at least 50 vaginal deliveries)

Resident who plan to have the option to incorporate high risk maternity care and surgical deliveries must complete the following additional training:

- Complete at least seven months (or 700 hours) of training on labor and delivery
    - Perform or directly supervise at least 80 vaginal deliveries (Core)
    - Perform or directly supervise at least 100 cesarean deliveries as primary surgeon (Core)
        - At least 40 of these must be repeat cesarean sections (core)
- Care for low and high risk pregnant women in the outpatient setting with at least 250 encounters (core) of these at least 100 encounters including high-risk pregnancies (core)

Residency practice quality measures related to competency in maternity care include:

- proportion of patients initiating prenatal care in first trimester
- primary cesarean section rate
- proportion of postpartum mothers using only breastmilk to feed their infants at hospital discharge
- proportion of postpartum mothers screened for depression.

number for deliveries and are required to have a family physician with intrapartum and newborn care privileges. Such requirements protect more programs from losing their ability to provide a minimum level of training than harm the long-term accreditation of programs who cannot meet these requirements. It also holds the standard for best training based on the available evidence.

The additional training for deliveries can be integrated into residency training or as a separate fellowship. Both levels would be recognized by the ABFM with separate focused practice recognitions. It is critical that we do not require a separate fellowship for intrapartum maternity care within family medicine. This will lead to fewer family physicians meeting this need and further specialization within the discipline, at a time when our maternity deserts need family physicians with a broad scope of practice that would be narrowed if we moved to a fellowship training model.

Conclusion

Maternity care continues to be a defining and essential feature of our specialty. No other specialty cares for the mother-baby dyad throughout the perinatal period and no other specialty routinely provides comprehensive primary care for women. If our society and the health care system want to address the inequities in health outcomes, particularly for rural and BIPOC women, we must embrace this challenge and train the next generations of family physicians to provide this care.

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