LETTERS
TO THE EDITOR

It's Time for Advocacy, in Response to "Family Doctors Delivering Babies? It's Time to Decide"

TO THE EDITOR:

When I read the editorial by Drs Winnie and Saultz in the May issue it certainly hit home as I considered my own personal plight as one of the "endangered species" of family physicians who practices high-risk surgical obstetrics, endoscopy, and provides intensive care to patients.[1] While the authors bring up important considerations concerning style of training and the merits of various methodologies, they miss one of the main reasons why a generalist cannot practice outside of the clinic.

Multiple times in my career I have had privileges restricted through overly-rigorous credentialing processes that do not account for quality measures, such as a family physician having excellent adenoma detection rates for colorectal cancer screening. If privileges are granted, soft-specialty discrimination frequently persists, and things like operating room time or specialty-biased referral processes are used to preclude the family physician from practicing. I am proud to have trained at a program known for producing generalists who go on to practice in rural or underserved areas, and now to teach at a different institution with a similar tradition. But a family physician should be able to practice those same skills wherever they hang their shingle or sign their employment contract.[2]

I am proud of our specialty's response to the challenges of the last year, but I have also watched mentors and colleagues fight battles for patient access and justice with their entire careers despite less pay or specialty disrespect.[3] In spite of challenges we are adjusting our strategies appropriately to ensure adequately trained residents.[4] However, these same residents then graduate unempowered to practice because of external factors—because of decisions already made against them.

The way forward is not just with additional curricula, or tracks, or apprenticeships. It is through action, and through advocacy and policy change that allows family physicians to practice how they were trained. Advocacy is needed not only for the sake of our vulnerable patients, but for our vulnerable fellow family physicians and their plight to care for those patients.

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Reply to "It's Time For Advocacy"

FROM THE EDITOR:

We are grateful to Dr Williamson for his kind comments[1] and for his comprehensive service to his patients and community. We agree that overly restrictive credentialing policies can stack the deck against family physicians in some communities and that this very real problem requires action. Dr Williamson suggests this action should be advocacy. We wonder what that means.

The word advocacy evokes discussions with legislators and large organizations, awaiting action to be taken by others on our behalf. This is certainly vital. However, it may take time, or may be ineffective. What are our patients, communities, and colleagues to do as we wait? Family physicians are also well poised to advocate locally by building self-efficacy.[2] For example, four family physicians in Texas leveraged their skill sets and services in a rural community resulting in expanded privileges in not just one hospital, but three.[3] Others partner with residency training environments to build

robust pipelines[4,5] and political capital to ensure continued opportunities for broad scopes of practice and better service to patients. Support can also come from outside our specialty; sometimes sympathetic administrators,[5] obstetricians, perinatologists,[6] or even patients and the public[7] can be key voices in the conversation. With our emphasis on community engagement and equity, family physicians are well poised to lead these changes.

We also should not forget our unique strengths in these conversations. Rather than simply advocating for family physicians to deliver babies, we should also emphasize the unique strengths of family-centered maternity care. Family physicians are the only physicians who can care for a pregnant woman along with her entire family during a vulnerable period. We are highly capable of delivering babies, caring for children as they grow, and maintaining the health of fathers and grandparents—all in the same day! Emphasizing that *only* family physicians can do this, can be a powerful strategy. If all of the family physicians in a community stand together, we can ask hospitals one powerful question: are you willing to give up the rest of what the family physicians in this community do just to keep them out of the delivery room?

We must use every available strategy to protect our scope of practice in a multitude of settings, but we have little chance of success if maternity providers are forced to stand alone. We should consider not only policy change, but also building grassroots movements, local consensus, and community relationships to keep a broad range of skills and services available to our graduates, colleagues, and patients.

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