2026, Volume 0, Issue 0, 1-2, e-ISSN 1938-3800

Family Medicine

LETTER TO THE EDITOR

Redefining Value in Family Medicine Obstetrics: A Pathway to Sustainable Rural Maternity Care

Jesus Ruiz, MD

AUTHOR AFFILIATION:
Family Medicine, The University of North Carolina at Chapel Hill, Chapel Hill

CORRESPONDING AUTHOR:
Jesus Ruiz, Family Medicine, The University of North Carolina at Chapel Hill, Chapel Hill, jesus_ruiz@med.unc.edu

HOW TO CITE: Ruiz J. Redefining Value in Family Medicine Obstetrics: A Pathway to Sustainable Rural Maternity Care. *Fam Med.* 2026;0(0):1-2.
doi: 10.22454/FamMed.2026.878048

FIRST PUBLISHED: May 20, 2026

TO THE EDITOR:

Fortenberry and colleagues provide an important and timely contribution by documenting the financial vulnerability of family medicine obstetrics (FMOB) fellowships, nearly half of which operate at a budget deficit.[1] Their analysis appropriately centers funding streams, billing practices, and the structural barriers created by lack of accreditation. Yet beyond the financial findings, this study surfaces a deeper and more consequential question: how value is defined in medicine—and who bears the consequences when that definition is narrowly financial.

In rural and underserved communities, sustainability is frequently invoked as an objective justification for the closure of maternity services. Low delivery volume is framed as synonymous with low value, and financial losses are presented as evidence of inevitability rather than as the product of policy choices and reimbursement structures. This logic has contributed to the steady erosion of local obstetric care across the United States, particularly in rural counties where hospital-based maternity units continue to close despite persistent community need.[2-5] FMOB fellowships exist precisely at this intersection of high social value and low financial margin, making them especially vulnerable within current systems of valuation.

The findings by Fortenberry *et al.* underscore this tension. FMOB fellowships disproportionately serve Medicaid and publicly insured patients,[1] populations whose care is systematically undervalued in fee-for-service models. Moreover, many of the benefits FMOB-trained physicians provide—avoided transfers, local access to operative delivery, continuity across pregnancy and postpartum, and stabilization of rural hospital obstetric capacity—accrue across systems rather than appearing neatly on a single hospital balance sheet.[6,7] When sustainability is assessed solely through direct revenue generation, these contributions remain largely invisible.

Notably, this study also highlights an educational gap. Fellowship directors, fellows, and early-career attendings are rarely trained to understand the financial and policy structures that shape their clinical environments. Medical education emphasizes clinical competence but often neglects systems literacy, leaving physicians ill-equipped to interrogate how metrics such as volume, productivity, and profitability are constructed—or to challenge narratives that equate financial loss with dispensability. As a result, many FMOB graduates enter practice unprepared to articulate their value to hospital leadership or to advocate effectively for the services their communities rely upon.

FMOB fellowships are uniquely positioned to disrupt this cycle. Beyond surgical and high-risk obstetric training, fellowships could intentionally incorporate education in health system finance, rural hospital economics, and value-based framing of care. Training fellows to measure and communicate outcomes such as reduced travel burden, improved continuity, workforce stabilization, and avoided maternal morbidity would equip graduates to engage meaningfully with administrators and policymakers.[6-9] Such preparation is not ancillary to clinical training; it is essential to sustaining practice in the very communities FMOB fellowships aim to serve.

If FMOB fellowships are to endure, the conversation must move beyond whether they can generate sufficient revenue within existing systems to whether our systems are willing to value what rural maternity care requires. Fortenberry *et*

al. have provided the data; the next step is operational. FMOB fellowships can begin by conducting targeted needs assessments to identify gaps in access, workforce capacity, and institutional support. Building on these findings, programs can integrate training in health system finance, policy, and value-based care to prepare graduates to engage with the systems in which they practice. Fellowships can also develop and track program-level measures of value, including continuity, local access to delivery, reduced travel burden, and workforce stabilization, and use these data to inform conversations with hospital leadership and policymakers. In doing so, they equip graduates to advocate for the role of FMOB within their communities. Redefining sustainability in this way, through assessment, measurement, and intentional training, offers a practical pathway to aligning fellowship viability with community need. Without such shifts, we risk continuing to train physicians for services our institutions remain unable to sustain.

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