

Supporting Family Physician Maternity Care Providers

TO THE EDITOR:

“Supporting Family Physician Maternity Providers” by Dr Goldstein and colleagues¹ is an excellent article that clearly describes what we need to do—*work together*. Alabama is predominantly rural and has one of the highest infant mortality rates in the country.² The College of Community Health Sciences (CCHS) at the University of Alabama in Tuscaloosa has developed an interdisciplinary, collaborative practice model with OB/Gyns and family physicians that provides obstetrical care to rural, underserved West Alabama.

Medical school and community Ob/Gyns and family physicians practicing obstetrics share call, cover for one another, and work together, including scrubbing together when needed to provide high quality obstetrical care. In rural communities where there are no labor and delivery services, family physicians and Ob/Gyns provide regionalized prenatal care. When their obstetrics patients need to be hospitalized (such as for delivery), the patients travel or may be transported to the teaching hospital in Tuscaloosa. Their physician who practices obstetrics may travel to the main hospital to deliver the patient or the patient may be cared for by the physician providing obstetrics care. There is always a physician who practices obstetrics in the hospital if the outlying physician cannot come to the delivery, does not make it to the delivery, or if the patient only needs postpartum or postoperative care provided. All physicians sharing hospital call allows each provider to be reimbursed for deliveries.

In Alabama, family physicians often provide obstetric care in rural areas.³ Family physicians care for the mother, the newborn and the rest of the family. Family physicians are almost never sued, and their malpractice insurance costs a fraction of what Ob/Gyns pay.⁴ Reimbursement is the same. Outcomes and complications are similar, and family physicians have lower cesarean section rates because they perform more vaginal births after cesarean sections resulting in less expensive care and shorter hospital stays.^{5,6} Family medicine physicians trained in obstetrical and newborn care is one of the methods that can help to reduce

maternal and perinatal morbidity and mortality in rural, underserved areas.

doi: 10.22454/FamMed.2019.636289

Daniel M. Avery, MD

Marion D. Reed, MD

Catherine A. Skinner, MD

University of Alabama School of Medicine, Department of Obstetrics and Gynecology
Tuscaloosa, AL

References

1. Goldstein JT, Hartman SG, Meunier MR, et al. Supporting family physician maternity care providers. *Fam Med*. 2018;50(9):662-671.
2. Alabama Vital Events, 1986-2014. Montgomery, AL: Center for Health Statistics, Alabama Department of Public Health. <http://www.alabamapublichealth.gov>. Accessed February 15, 2019.
3. Rayburn WF, Klagholz JC, Murray-Krezan C, Dowell LE, Strunk AL. Distribution of American Congress of Obstetricians and Gynecologists fellows and junior fellows in practice in the United States. *Obstet Gynecol*. 2012;119(5):1017-1022.
4. Avery DM. Why family physicians should practice obstetrics. *Am J Chin Med*. 2008;5:32-34.
5. Avery DM, Waits S, Parton JM. Comparison of delivery related complications among obstetrician/gynecologists and family obstetricians practicing obstetrics. *Am J Clin Med*. 2014;10:21-25.
6. Avery DM, Graettinger KR, Waits S, Parton JM. Comparison of delivery procedure rates among obstetrician/gynecologists and family physicians practicing obstetrics. *Am J Clin Med*. 2014;10:16-20.

Burnout in Family Physician Maternity Care Providers?

TO THE EDITOR:

We appreciate Goldstein and colleagues' comprehensive, thoughtful article summarizing strategies to support family physician maternity care providers and we share their aim to reverse the trend of fewer family physicians providing maternity care.¹ However, we were surprised that the authors identified burnout as a possible reason for leaving maternity care practice, and disappointed that they did not use a more precise definition of burnout.²

The authors defined burnout as “being at high risk for leaving maternity care practice.” Perhaps a more widely-accepted definition of burnout could have been used, such as “a psychological syndrome in response to chronic interpersonal stressors on the job... three key dimensions of this response are an overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment.”³ For many contemporary physicians, causes of

burnout may not be the burden of traditional “doctoring” work, such as caring for pregnant women, delivering babies, and providing newborn care, but more modern practice demands, such as documentation, asynchronous communication, and productivity pressure.

It is certainly possible that burnout contributes to physicians’ decisions to leave maternity care practice. However, if we are to reverse the attrition of family physicians from the maternity care workforce, it is important that we identify and define the real causes. In our community, many family physicians have recently stopped providing inpatient maternity care. When questioned about why, the most common reason given was not burnout, but rather the competing demands of personal life. This theme is supported by literature, which indicates that family physicians stop practicing obstetrics primarily because of logistical considerations, including the demands of on-call time, family needs, and concerns about maintaining competence.⁴ More research is needed to better understand the motives of family physicians who stop delivering maternity care, and more importantly, to identify system changes that can make maternity more care feasible for contemporary family physicians.

Labeling “being at high risk for leaving maternity care practice” as burnout implies that practicing maternity care contributes to burnout, but evidence suggests the contrary. Recently, Weidner and colleagues published a secondary analysis of the 2016 National Family Medicine Graduate Survey, which asked family physicians 3 years after residency graduation about self-reported burnout. Their evidence suggests that providing maternity care is protective against burnout (OR=0.64; 95% CI, 0.47-0.88; $P=.0058$), at least for new physicians.⁵

Perhaps we should propose that family doctors provide maternity care as an antidote to burnout. Although maternity care is real work, we who deliver this care find that it brings us real joy. Contrary to the burnout definition above, it promotes a sense of connection with patients and families, professional effectiveness, and accomplishment. By delivering maternity care, we stay connected with our rich history and identity as family physicians, while simultaneously providing a service our communities desperately need.

In any event, we should be careful about our definitions, and seek to better understand how we can reverse the loss of maternity care from family medicine practice.

doi: 10.22454/FamMed.2019.323076

Steven E. Roskos, MD

James Olson, MD

Julie Phillips, MD, MPH

Michigan State University College of Human Medicine,
Department of Family Medicine and Sparrow/MSU Family
Medicine Residency Program
East Lansing, MI

References

1. Goldstein JT, Hartman SG, Meunier MR, et al. Supporting family physician maternity care providers. *Fam Med*. 2018;50(9):662-671.
2. Schwenk TL, Gold KJ. Physician burnout—a serious symptom, but of what? *JAMA*. 2018;320(11):1109-1110.
3. American Academy of Family Physicians. Family Physician Burnout, Well-Being, and Professional Satisfaction (AAFP Position Paper). 2017. <https://www.aafp.org/about/policies/all/physician-burnout.html>. Accessed December 4, 2018.
4. Dove M, Dogba MJ, Rodríguez C. Exploring family physicians’ reasons to continue or discontinue providing intrapartum care: qualitative descriptive study. *Can Fam Physician*. 2017;63(8):e387-e393.
5. Weidner AKH, Phillips RL Jr, Fang B, Peterson LE. Burnout and Scope of Practice in New Family Physicians. *Ann Fam Med*. 2018;16(3):200-205.

We Are Better Together: Committed Partnerships in Global Health Development

TO THE EDITOR:

I enjoyed the thorough analysis of developing family medicine programs across the globe provided by Rouleau, Bourget, Chege, and colleagues in their recent article “Strengthening Primary Care Through Family Medicine Around the World: Collaborating Toward Promising Practices.” In this article, the authors highlighted four keys to developing family medicine programs: champions, policy windows, an adaptable core, and committed partnerships.¹ I would like to continue the conversation by focusing on the development of committed partnerships and how this relates to global health curricula in graduate medical education.

In 2010, Crump and Sugarman recognized that while beneficial for learners, not all global health experiences benefit the intended vulnerable populations. In response, they introduced the WEIGHT guidelines to provide a detailed framework for the development of ethical global health programs. These guidelines emphasize the need for a well-structured partnership between sending and host institutions. Melby, et al then introduced four ethical principles to guide the development of global health experiences in their 2016 paper. This included the principle of bidirectional participatory relationships, which moved us past respectful ethical partnerships and opened the floor for shared knowledge between high-income

countries (HICs) and low-and-middle-income countries (LMICs).³

It is in this context that I also invite the reader to review Beau de Rochars and colleagues' recent article describing the state of medicine and medical education in Haiti.⁴ They accurately highlight the harm that can be incurred when short-term missions are not undertaken with enough care to their consequences. Both the void of follow-up care after foreign physicians leave and the impact on public opinion toward local medical professionals are real and damaging consequences described in this article.⁴

There is hope. When reading Rouleau, et al's article, I was struck by the innovation displayed by each country represented. For family medicine to expand and improve public health outcomes throughout a multitude of environments and cultures, we must have ingenuity and innovation. Haiti is no exception, and Beau De Rochars and colleagues' plea for help in training Haitian providers⁴ should not fall on deaf ears. By partnering existing medical education institutions with developing family medicine programs around the world, we can harness the passion of our learners with the ingenuity of those practicing medicine in other cultures, thereby fostering the exact committed partnerships that Rouleau, et al refer to. By sharing our innovations in family medicine across cultures, we all have more to gain. doi: 10.22454/FamMed.2019.322350

Christine Young, MD

Mount Carmel Family Medicine Residency
Westerville, OH

References

1. Rouleau K, Bourget M, Chege P, et al. Strengthening primary care through family medicine around the world: collaborating toward promising practices. *Fam Med*. 2018;50(6):426-436.
2. Crump JA, Sugarman J; Working Group on Ethics Guidelines for Global Health Training (WEIGHT). Ethics and best practice guidelines for training experiences in global health. *Am J Trop Med Hyg*. 2010;83(6):1178-1182.
3. Melby MK, Loh LC, Evert J, Prater C, Lin H, Khan OA. Beyond medical "missions" to impact-driven short-term experiences in global health (STEGHs): ethical principles to optimize community benefit and learner experience. *Acad Med*. 2016;91(5):633-638.
4. Beau De Rochars VM, Cadet JC, Mainous AG III. Global health: a view from the school of medicine of L'Université d'État d'Haiti. *Fam Med*. 2018;50(4):259-261.

Family Medicine Research "Bright Spots" in Low-Resource Settings

TO THE EDITOR:

We applaud the article, "Factors Associated With Successful Research Departments: A Qualitative Analysis of Family Medicine

Research Bright Spots" by Dr Liaw and colleagues.¹ It gives us great hope for what is possible in the field of family medicine research. This study focuses on research bright spots within a well-developed infrastructure. The authors state "while intrinsic motivation was important, leaders also indicated that it was insufficient in isolation without resources." This raises a common question: what about programs without resources?

We contend the principles—multidisciplinary collaboration, leadership support, mentorship, etc—are easily applicable in low-resource research settings. Grassroots development of successful research teams can grow up around physician innovators with "fire in [their] belly"¹ as they utilize the principles of success presented in this paper. In so doing, research teams create their own research "microsystem," not dissimilar to the infrastructure of these bright spots, though much smaller in size. This is especially pertinent to the residency environment, as scholarly activity is mandated by the Accreditation Council for Graduate Medical Education (ACGME).²

Take our experience for example. As a group of family medicine residents, we initiated a study to investigate the impact of group pregnancy care on maternal and fetal outcomes. Like many residents, we lacked time, funds, and practical research experience.^{3,4} Similar to these institutional bright spots, we built our own miniresearch network within the walls of our residency clinic, with medical technicians and clinical nurses quickly becoming our strongest research allies. The success or failure of this project relied on the trust shared within this multidisciplinary team. When faced with the barrier of time, we sought out leadership and worked to make the project relevant to their goals as well as ours, resulting in increased protected time for our team. When faced with a low return rate of our survey instruments, we identified strategic, real-time changes that resulted in significant benefits. When faced with minimal buy-in from other departments, we assembled an interdepartmental steering committee, facilitating interactions between stakeholders and growing a culture of collaboration.

The qualitative report of Liaw and colleagues is an important first step. Next, it is essential to perform a similar qualitative evaluation of research bright spots that are growing up amidst minimal resources. Their insight would be broadly applicable and may propel more research microsystems to become future bright spots.

doi: 10.22454/FamMed.2019.425475

Christine Broszko, MD

Eglin Air Force Base Family Medicine Residency Program
Eglin Air Force Base, FL

Kirsten Winnie, MD

Travis Family Medicine Residency Program
Travis Air Force Base, Fairfield, CA

Amy Whittle, MD

Staff Physician, Holloman Family Health Clinic
Holloman Air Force Base, NM

DISCLAIMER: The views expressed are those of the authors and do not reflect the official policy of the Department of the Air Force or the United States Government.

References

1. Liaw W, Eden A, Coffman M, Nagaraj M, Bazemore A. factors associated with successful research departments: a qualitative analysis of family medicine research bright spots. *Fam Med.* 2019;51(2):87-102
2. Accreditation Council for Graduate Medical Education. ACGME Common Program Requirements [internet]. https://www.acgme.org/Portals/0/PFAAssets/ProgramRequirements/CPRs_2017-07-01.pdf. Accessed December 4, 2018.
3. Ledford CJ, Seehusen DA, Villagran MM, Cafferty LA, Childress MA. Resident scholarship expectations and experiences: sources of uncertainty as barriers to success. *J Grad Med Educ.* 2013;5(4):564-569.
4. Rothberg MB. Overcoming the obstacles to research during residency: what does it take? *JAMA.* 2012;308(21):2191-2192.

Reply to “Family Medicine Research ‘Bright Spots’ in Low-Resource Settings”

TO THE EDITOR:

We thank the authors for their insightful comments and wholeheartedly agree that studying residency programs is an important next step in this line of inquiry. Throughout our interviews with bright spots, residents, residency faculty, and residency programs played prominent roles. First, because they practice on the front lines, residents and residency faculty generate a lot of questions that have high relevance to family medicine. Second, researchers within bright spots were often identified during residency. Bright spot leaders described residencies as pipelines for faculty generally and researchers specifically. One leader looks for residents that can “think like... researcher[s],” or have “curiosity and passion that suggests they’re likely to ask and answer important questions.”¹

While residencies are important to bright spots, we believe that they are, by themselves, essential to the success of the family medicine research enterprise. Bright spots represent a concentration of resources and expertise, but important research questions (like the authors’ project to improve maternal and fetal outcomes) are being asked and answered across the entire family medicine network. As the

authors suggested, the themes we identified can be used by individuals working in low-resource settings to stimulate research. Engaged and committed program directors can value research and allocate the resources needed to support it. Residencies can acquire needed skills and resources by partnering with other departments, residencies in other specialties, training programs for other health professionals, and community organizations. Residencies often already have retreats to build trust among trainees going through a shared experience. Researchers can be included in these activities so that residents develop trust with them as well. Finally, residents already generate important questions that are critical to their identities as family physicians and the discipline as a whole. Faculty with research or quality improvement skills can work with residents to enhance the clarity and feasibility of these questions.

When conducting this study, we were concerned that our colleagues would view bright spots as beyond their reach, and therefore would never start the journey toward continuous learning. We hoped that these lessons would encourage others to consider the assets that are, at present, in their clinics, systems, and communities. These authors remind us that important, impactful work is already taking place at residencies nationwide and that there are new lessons to learn from them.

doi: 10.22454/FamMed.2019.527150

Winston Liaw, MD, MPH

Department of Health Systems and Population Health Sciences, University of Houston College of Medicine
Houston, TX

Aimee Eden, PhD, MPH

American Board of Family Medicine
Lexington, KY

Megan Coffman, MS

Robert Graham Center
Washington, DC

Meera Nagaraj

Davidson College
Davidson, NC

Andrew W. Bazemore, MD, MPH

Robert Graham Center
Washington, DC

Reference

1. Liaw W, Eden A, Coffman M, Nagaraj M, Bazemore A. factors associated with successful research departments: a qualitative analysis of family medicine research bright spots. *Fam Med.* 2019;51(2):87-102.

In Response to the Entire January Issue of Family Medicine

TO THE EDITOR:

In my day-to-day work, annoying frustrations are common. Simple glitches in managing the electronic health record, financial pressures that threaten quality, and an informal curriculum that maligns my chosen discipline occasionally put me at risk of becoming discouraged. Sometimes, they build to a point where my focus of attention shifts to the burdens of being a clinician-educator in family medicine rather than its satisfactions.

That is why I am now grateful to the authors, editors, and STFM leaders who have made the recent dedicated issue of *Family Medicine* possible. Their contributions have helped me refocus my attention on values I have long believed to be central to my professional identity. Their dedication has inspired me to remember why I chose to do this work in the first place.

Fundamentally, the articles in this issue—and the disparities in the United States they discuss—are about racism.¹⁻³ Of concern is well over 400 years of injustice, including both the existence of black African slaves in North America and our country's collective inability to deal with this history and its reverberations over time.

Issues of power, class, money, and the various political and economic ideologies that infuse our national consciousness also obviously contribute to discussions on racism. From a bio-psycho-eco-social viewpoint, anxiety, fear, and insecurity in the face of the “other”—anyone who might look, think, or act in ways that appear to threaten our sense of integrity as human beings—also play critical roles. I state this as an aging, Caucasian male from Minnesota, now making my way in Arkansas. I honestly believe these points of view apply universally to each of us, albeit from radically different perspectives depending on which side of the societal and emotional divide one sees him or herself.

As many of the articles point out, a social justice orientation is key to addressing these issues. In fact, a distinguished outsider to our discipline—Steven Schroeder, MD, former President and CEO of the Robert Wood Johnson Foundation—recently wrote that social justice forms the moral core of family medicine.⁴ To his five recommendations for reinforcing that core and the importance of family medicine (Table 1), however, I add one more.

We as family physician educators must nurture our signature presence as healers⁵—working individually with patients and collectively through community engagement—toward the reconciliation of past and present injustices, the recognition of our interdependency with others, and the acknowledgment of fear in the face of suffering. We must do this in our daily work, modeling our intentions to both the patients we care for and the new generations of physicians we train. We must also do this in other important venues where policies are shaped, as visionaries, advocates, and administrators, over the long haul of our careers.

Reading the articles in January's *Family Medicine*, all dedicated to disparities in health outcomes, I felt proud to be a family physician and a member of STFM.

doi: 10.22454/FamMed.2019.625056

William Ventres, MD, MA

Department of Family and Preventive Medicine, University of Arkansas for Medical Sciences
Little Rock, AR

Table 1: Recommendations for Supporting Academic Family Medicine⁴

- | |
|---|
| <ol style="list-style-type: none"> 1. Address social and moral issues in medicine 2. Offer personal care 3. Enlist potential allies 4. Support the institutional value of generalism 5. Appreciate the joys of practicing and teaching family medicine |
|---|

References

1. Nguyen B-M. The most shocking and inhuman. *Fam Med.* 2019;51(1):5-7.
2. Wilson SA. Racism is real. Racism is complicated. Racism is real complicated. *Fam Med.* 2019;51(1):8-10.
3. Steiner B, Chen FM, Brungardt SH, Wilson SA. In it together for the long run. *Fam Med.* 2019;51(1):64-66.
4. Schroeder SA. Social justice as the moral core of family medicine: a perspective from the Keystone IV conference. *J Am Board Fam Med.* 2016;29(suppl 1):S69-S71.
5. Ventres WB. How I think: perspectives on process, people, politics, and presence. *J Am Board Fam Med.* 2012;25(6):930-936.