Self-advocacy guide for family physicians advocating to hospitals/health systems for obstetrics privileges

Introduction

The American Academy of Family Physicians (AAFP) developed this guide to support family physicians in advocating for their full scope of family medicine. Family physicians play a crucial role in providing comprehensive care to patients, and their ability to offer pregnancy care to patients is an essential component of this care. However, many family physicians face significant barriers when practicing full-scope care, including challenges with hospital privileges, malpractice insurance costs and lifestyle concerns.

This guide aims to equip family physicians with information and strategies to effectively communicate and negotiate with privileging and credentialing committees and hospital administration. By addressing common concerns and misconceptions about family physicians' ability to provide pregnancy care, the AAFP seeks to empower family physicians to advocate for their right to provide full-scope care, ultimately improving patient care and health outcomes.

Key messages[1]

- Family physicians deliver safe, effective and cost-efficient pregnancy care with health outcomes comparable to obstetricians-gynecologists (OB-GYNs), especially for low-risk pregnancies and in rural settings.
- Family physicians are essential for maintaining access to maternity care, especially in underserved areas. In some places, they are the only clinicians delivering babies.
- Family physicians who provide pregnancy care have lower rates of cesarean sections, higher patient satisfaction scores and better economic outcomes for communities than OB-GYNs.

Family physicians in the obstetrics workforce

Family physicians comprise 17% to 23% of the physician workforce who deliver babies, delivering somewhere between 120,000 to 230,000 babies annually.[2] But, there has been a significant decline in family physicians providing pregnancy care in the United States, dropping from 23.3% in 2000[3] to 5% in 2016.[4] Family physicians practice pregnancy care (including in the prenatal and postpartum periods) in post-residency practice at much smaller rates when compared to their stated intent to do so during residency.[5]

Factors that contribute to family physicians not providing pregnancy care include[6-11]:

- Not being able to find a family medicine role that includes pregnancy care
- Concerns of geographic limitations, such that family physicians who provide pregnancy care are often confined to rural and/or critical access areas with minimal backup support
- Low volume of delivery opportunities
- Challenges with privileging
- Difficulties with interdisciplinary relationships, especially with obstetricians
- Perceived bias against family medicine
- Lifestyle concerns, like unpredictable work hours and call schedules
- Malpractice insurance costs
- Fear of potential liability

Preserving the breadth and depth of full-scope family medicine is vital to improving access to maternity care. Family physicians can fill gaps in maternity care since they practice in many counties where other clinicians and specialists do not. In the United States, 6.9 million women of childbearing age live in areas with low or no access to maternity care, and access to maternity care is projected to worsen over time.[12] The American Congress of Obstetricians and Gynecologists projects that by 2050, there will be a shortage of 22,000 OB-GYNs.[13] Currently, 40% of U.S. counties do not have an obstetrician or midwife.[6] Conversely, only 6.5% of counties in the United States lack a family physician, providing an incredible opportunity to fill the maternity care gap.

Family physician training in obstetrics

All family physicians are trained and competent to "provide care for low-risk patients who are pregnant, to include management of early pregnancy, medical problems during pregnancy, prenatal care, postpartum care and breastfeeding."[14] Many family physicians pursue additional training within residency to provide intrapartum care for

low-risk pregnancies and some moderate-risk pregnancies, including vaginal deliveries. Some family physicians pursue further training to include managing high-risk pregnancies and cesarean deliveries.

Family physicians are uniquely trained to provide a wide range of services—from prenatal to postnatal care—ensuring patients receive consistent, personalized care throughout their pregnancy. This holistic approach improves patient satisfaction and health outcomes and fosters long-term patient relationships, which can lead to increased patient loyalty and retention.

According to the Accreditation Council for Graduate Medical Education (ACGME), during residency, all family physicians must demonstrate competence to independently provide care to patients who may become pregnant, including[15]:

- Diagnosing pregnancy and managing early pregnancy complications
- Low-risk prenatal care
- Care of common medical problems arising from pregnancy or coexisting with pregnancy
- Performing an uncomplicated spontaneous vaginal delivery
- Demonstrating basic skills in managing obstetrical emergencies
- Postpartum care, to include screening and treatment for postpartum depression, breastfeeding support and family planning

Recently adopted changes to the ACGME Program Requirements for Graduate Medical Education in Family Medicine state that all residents must have at least 200 hours dedicated to participating in pregnancy-related care, including experience with a minimum of 20 vaginal deliveries. Residents who choose to incorporate care of patients on labor and delivery and vaginal deliveries into independent practice must complete 400 hours of training on labor and delivery and perform or directly supervise at least 80 deliveries.

The training of independent practices on labor and delivery procedures prepares family physicians for the following:

- Antepartum management of common pregnancy and medical problems
- Management of first-trimester bleeding
- Management of low-risk and moderate-risk labor, including labor inductions
- Management and interpretation of electronic fetal monitoring
- Performance/supervision of common intrapartum procedures
- Performing spontaneous vaginal deliveries
- Managing common obstetrical emergencies, including shoulder dystocia and postpartum hemorrhage
- Repair of 1st and 2nd degree vaginal/perineal lacerations and episiotomies
- Perform/supervise newborn circumcision

Training in advanced obstetric skills, including cesarean delivery, may be pursued in residency or as part of a family medicine fellowship in obstetrics.[16,17] Residents who want to perform cesarean deliveries as part of their practice should be able to achieve proficiency within traditional family medicine residencies.[18] If a family physician desires additional training in cesarean delivery, there are four-year family medicine residencies with surgical maternity tracks[19] and approximately 60 family medicine fellowships in surgical obstetrics.[20]

Some physicians choose to obtain board certification in family medicine obstetrics or family medicine obstetrics with surgical qualification through the American Board of Physician Specialties.[21] Physicians can meet the eligibility criteria for this certification during training and in clinical practice.

Applying for credentials and privileges

When preparing to apply for privileges and credentials, visit the AAFP's webpages on credentialing and privileges for family physicians and how to obtain credentials and privileges. More comprehensive information can be found at the links listed, but a summary is provided below[22]:

- Thoroughly review the hospital's medical staff bylaws before requesting an application.
- Gather and make copies of the required documentation. Ensure you have updated documentation of education, training, experience and competence (i.e., a procedure log with cases from the past two years). This may also include letters of reference from colleagues.
- Request that all specific information about privileging decisions be submitted in writing.

The position of the AAFP on privileging

Privileges should be granted based on training, experience and demonstrated current competence.[23] Since 1998, the AAFP and the American College of Obstetricians and Gynecologists (ACOG) have supported the AAFP-ACOG Joint Statement on Cooperative Practice and Hospital Privileges, which states that "all physicians should be held to the same standards for granting privileges." Both organizations acknowledge that the collaboration between family physicians and OB-GYNs is essential for providing consistent, high-quality care to pregnant persons.

The AAFP believes all physicians should be held to the same standards when granted privileges, regardless of specialty.[24] Overlap exists among many specialties, and no single department owns or has exclusive rights to any privileges. In departmentalized hospitals, privileges for family physicians should be recommended by their department of family medicine. AAFP policies related to privileges are "in

line with the policies of other organizations with influence on credentialing and privileging, including the American Medical Association and The Joint Commission."[16]

The AAFP has additional policies and position papers related to proctoring and privileging that may be relevant when applying for credentials and privileges in obstetrics or pregnancy care, including:

- Privileging, family medicine
- Cesarean delivery in family medicine (position paper)
- Pregnancy, perinatal and newborn care by family physicians
- Preconception care (position paper)
- Prevention and management of sexually transmitted infections
- Professional competence evaluation
- Clinical proctoring

Common core privileges for family medicine obstetrics

While privileging decisions are determined at each hospital, the following core obstetrics privileges are common across family medicine.[25]

Family medicine common core privileges list for gynecology

- Admission to hospital
- Evaluation, history, physical and treat postpubescent female patients with injuries and disorders of the female reproductive system and the genitourinary system
- Treating disorders of menstruation, perimenopause and postmenopause, including osteoporosis
- Procedures include, but are not limited to, the following:
  - Normal gynecological examinations, including breast exam
  - Gynecological cancer screening
  - Bartholin duct cyst drainage or marsupialization
  - Colposcopy with or without cervical biopsy
  - Cryosurgery/cautery for benign disease
  - Endocervical curettage
  - Endometrial biopsy
  - Excision/biopsy of vulvar lesions
  - Insertion/removal of intrauterine device
  - Insertion/removal of Nexplanon
  - Medical management of abortion (spontaneous or therapeutic)
  - Removal of foreign body from vagina
  - Suturing of uncomplicated lacerations
  - Uterine curettage following incomplete abortion

Family medicine common core privileges list for obstetrics

- Admission to hospital
- Evaluation, diagnosis, history, physical exam, treatment and management of low-risk term pregnant patients, labor and delivery and postpartum care
- Procedures include, but are not limited to, the following:
  - Amniotomy
  - Assist at cesarean section
  - Contraction stress test
  - Emergency care for patients of all ages
  - Episiotomy
  - Excision/biopsy of vulvar lesions at delivery
  - Fetal monitoring (internal and external)
  - Induction of labor and augmentation of labor with or without cervical ripening
    - Management of prolonged labor suggesting dystocia in consult with surgical backup
    - Management of second-stage arrest of labor in consult with surgical backup
    - Management of postpartum endometritis or other causes of postpartum fever
  - Manual removal of placenta, post-delivery
    - Non-stress test
    - Non-surgical management of post-partum hemorrhage
  - Obstetric (OB) ultrasound
    - Amniotic fluid index
    - Biophysical profile
    - Cervical length
    - Early dating/viability
    - Fetal survey ultrasound
    - Limited OB ultrasound
    - Position of fetus ultrasound
    - 1st, 2nd and 3rd trimester OB ultrasound
  - Outlet operative vaginal delivery (forceps or vacuum)
  - Pudendal anesthesia
  - Repair of episiotomy
  - Repair of uncomplicated vaginal or cervical lacerations (1st and 2nd degree)
  - Suturing lacerations (including layer closure)
  - Trial of labor after cesarean/vaginal birth after cesarean (TOLAC/VBAC) in consult with surgical backup

Family medicine advanced procedures which require documentation of additional training:

- Dilation and curettage (D&C), including suction and postpartum
- Dilation and evacuation of the uterus up to 12 weeks of pregnancy
- Loop electrosurgical excision procedure (LEEP)
- Primary on cesarean section
- Post-partum tubal ligation
- Tubal ligation at cesarean section
- Post-partum salpingectomy (for contraception)
- Salpingectomy at cesarean section
- Repair of vaginal and cervical laceration and extensions (3rd and 4th degree)

Family medicine common core privileges list for pediatrics

- Admission to hospital (including newborn nursery)
- Evaluation, diagnosis, consult, history, physical exam, treatment and management of newborns
- Procedures include, but are not limited to, the following:
  - Circumcision
  - Frenotomy
  - Interpretation of electrocardiograms (ECG/EKG)
  - Local anesthetic techniques
  - Lumbar puncture
  - Management of uncomplicated minor closed fractures and dislocations
  - Vascular access and intubation of newborns (with Neonatal Resuscitation Program [NRP] certification)

Literature findings regarding family physicians providing pregnancy care

- Studies have shown no difference in competency skills between family physicians and OB-GYNs.[26,27]
- Patient outcomes are comparable when family physicians are involved in deliveries to those of OB-GYNs.[28]
- Family physicians are vital for patients to access maternity care. In some areas, they are the only clinicians delivering infants.[29]
- Family physicians provide cost-effective care that benefits patients, hospitals and communities.[30]

Details about study designs and findings from many of the studies cited below can be found in the annotated bibliography, [Family Medicine in Obstetrics: The Critical Role of Family Physicians in the Perinatal Workforce].

Patient outcomes when family physicians deliver babies

- Family physicians deliver babies by cesarean section at lower rates than OB-GYNs.[6,18,27,31,32]
  - Family physicians also care for patients with higher social risk factors than OB-GYNs without compromising the quality of prenatal care or pregnancy-related outcomes, including performing lower rates of cesarean deliveries.[33]
  - One study found that family physician-only labor and delivery units have a 34.3% lower risk of cesarean delivery than hospitals with family physicians and OB-GYNs.[31]
- Family physicians use fewer interventions (i.e., amniotomy, induction, epidural, oxytocin) and are more likely to facilitate spontaneous vaginal deliveries than OB-GYNs.[26,32]
- Labor and delivery units with family physicians have strong safety cultures and are more supportive of vaginal birth.[6,31]
- Neonatal outcomes, pernatal mortality and morbidity are similar when comparing deliveries by family physicians and OB-GYNs.[27,28,34]
- Patients who had a cesarean delivery performed by a family physician did not face increased overall risk.[26]
- The continuity of care provided by family physicians is linked to improved health outcomes and lower hospitalization rates.[28] It ensures that patients receive care that integrates medical, social and emotional support from providers they know and trust.
- Patients report higher satisfaction with family physician-led deliveries compared to specialist obstetric care.[35]

Family physicians play a vital role in access to material care in the United States

- Family physicians deliver safe, high-quality and patient-centered obstetric care, especially in rural and underserved areas.[36,37]
- Family physicians are the specialists most likely to be present in rural areas, ensuring continuity of care and supporting local health infrastructure.[38-40]
- In 27% of rural hospitals, family physicians are the sole delivering physicians.[37,41]
- Family physicians often serve more vulnerable populations (younger age at delivery, lower education, Medicaid insurance coverage and tobacco use during pregnancy) and achieve outcomes comparable to OB-GYNs.[33]
- In the United States, 41% of births are financed by Medicaid.[42]
- Family physicians are uniquely positioned to address gaps in care for underserved populations due to their ability to manage a wide range of health issues, including substance use and chronic disease,[43] alongside maternity care.[44]
- Family physicians display less bias toward patients with obesity than OB-GYNs.[45]

Business case for family physicians providing pregnancy care

- Family physicians provide cost-effective care for low-risk deliveries with health outcomes comparable to or better than those of OB-GYNs.[6,28,46] Family physicians' broad skill set allows them to address various health issues beyond pregnancy, such as managing acute and chronic conditions for the pregnant person and their family.[47] They streamline care delivery, increase accessibility and potentially lower health care costs.[46]
- Family physicians strengthen local economies. Quality health care, including maternity services, is essential for local communities. It is linked to economic development and community growth.[48]
- Family physicians improve hospital sustainability in communities. The economic impact of family physicians practicing obstetrics in rural areas is substantial, supporting hospital viability and attracting and retaining businesses and residents.[49]
  - A 2014 study found that a family physician practicing obstetrics adds $488,560 in economic benefit to the community, in addition to the $1 million in economic benefit from practicing family medicine.
- Family physicians who practice pregnancy care are less likely to report burnout, contributing to longer retention and greater workforce stability.[50,51]

Fostering relationships

A strong working relationship with colleagues in OB/GYN and other specialties within a health system can create buy-in and confidence in family physicians who provide pregnancy care. It is also important to promote a safety culture and coordinated care for patients requiring higher levels of care. If you ever encounter an issue with privileges, the following are suggestions you can use to help strengthen interdisciplinary relationships and offer support[4]:

- Designate a representative from your department of family medicine to serve on a privileging and credentialing committee
- Designate a representative from your department of family medicine to serve on your institution's safety and quality committees for perinatal care
- Serve on other interdisciplinary committees or work groups
- Share workspace, triage, rounding and call
- Host an interdisciplinary journal club and case reviews
- Teach Advanced Life Support in Obstetrics (ALSO) and Basic Life Support in Obstetrics (BLSO) courses in your health system and encourage people from other disciplines to obtain training and assist in teaching courses
- Develop collaborative agreements

Community members' advocacy for family physicians to care for pregnant patients can be key to maintaining their scope of practice, clinical volumes and comprehensive care. Community partners and former or current patients can be asked to provide testimony or evidence for the need for family physicians to provide pregnancy care in their communities. A sample letter of support is available on the AAFP's website. Other ways family physicians can collaborate and increase their involvement in pregnancy care include[4,52]:

- Collaborating with community partners to fill a need
- Collaborating with local doulas
- Offering Centering Pregnancy (or another model of group care)
- Offering free pregnancy tests
- Consulting or serving as a medical advisor on community task forces or work groups
- Ensuring that patients and insurance providers are aware that family physicians provide maternity care

What to do if you encounter challenges applying for obstetrics privileges

If you experience a denial or a restriction of privileges, thoroughly review the information on the AAFP's How to handle a hospital privilege dispute webpage. The webpage goes into further detail, but some basic steps are to[53]:

- Identify the issue. What are the cited grounds for this decision? Are you missing documentation? A sample letter to send to a privileging committee outlining the AAFP's policies on privileging is available on the AAFP's website.
- Seek support from your department and other physicians you work with. Letters of support to the committee may assist in a resolution.
- Contact your AAFP chapter and the AAFP. They may suggest actions you should take, and your chapter can help you understand state laws related to the scope of practice. When appropriate, they will write letters of support. If you are considering legal counsel regarding hospital privileging, you must involve your AAFP chapter in order to seek legal support from the Academy, per the AAFP's Privilege support protocol.
- Understand your avenues for appeal and request a hearing. Understand your hospital's medical bylaws process for appeals. Use this guide to help you cite evidence of family physician training, experience and competence.

Acknowledgements

The AAFP would like to thank the following reviewers (who also served on the Advisory Committee) for their contributions to this guide: Bindusri Paruchuri, MD, FAAFP; Wendy B. Barr, MD, MPH, MSCE, FAAFP; Nicholas Schenk, MD, FAAFP; Tyler Barreto, MD, MPH, FAAFP; and Kelsie A. Kelly, MD, MPH.

The AAFP would like to also thank members of the Advisory Committee whose work informed the content of this guide: C. Peony Khoo, MD, FAAFP; Renee Crichlow, MD, FAAFP; John Cullen, MD, FAAFP; Shani Muhammad, MD, FAAFP, Mark Loafman, MD, MPH; Divya Reddy, MD, MPH; Karen Mitchell, MD, FAAFP; Janet Hurley, MD, MBA, FAAFP; and Samantha Elwood.

References

1. Hampton S. Why aren't we using family medicine to help confront the maternal mortality crisis in the United States? *Birth.* 2025;52(2):169-172.
2. Robert Graham Center. Family physicians provide maternity care to hundreds of thousands of women. November 19, 2021. Accessed October 30, 2025. www.aafp.org/dam/rgc/documents/publications-reports/reports/RGC-Report-FamilyPhysiciansMaternityCare.pdf
3. Tong STC, Makaroff LA, Imam M, et al. Proportion of family physicians providing maternity care continues to decline. *J Am Board Fam Med.* 2012;25(3):270-271.
4. Goldstein JT, Hartman SG, Meunier MR, et al. Supporting family physician maternity care providers. *Fam Med.* 2018;50(9): 662-671.
5. Sutter MB, Prasad R, Roberts MB, et al. Teaching maternity care in family medicine residencies: what factors predict graduate continuation of obstetrics? A 2013 CERA program directors study. *Fam Med.* 2015;47(6):459-465.
6. VanGompel EW, Singh L, Carlock F, et al. Family medicine presence on labor and delivery: effect on safety culture and cesarean delivery. *Ann Fam Med.* 2024;22(5):375-382.
7. Eden AR, Barreto T, Hansen ER. Experiences of new family physicians finding jobs with obstetrical care in the USA. *Fam Med Community Health.* 2019;7(3):e000063.
8. Barreto TW, Taylor MK, Goldstein JT, et al. Retaining the perinatal care workforce: lessons learned from experienced physicians who no longer attend deliveries. *Health Serv Res.* 2024;59(1):e14224.
9. Taylor MK, Barreto T, Goldstein JT, et al. Providing obstetric care: suggestions from experienced family physicians. *Fam Med.* 2023;55(9):582-590.
10. Eden AR, Peterson LE. Challenges faced by family physicians providing advanced maternity care. *Matern Child Health J.* 2018;22(6):932-940.
11. Credentialing Resource Center. Family medicine and the role of obstetrics: is it obsolete? Medical staff briefing. Vol. 28. Issue 2. Accessed October 30, 2025. https://credentialingresourcecenter.com/membership-check?destination=/node/12220
12. March of Dimes. Maternity care deserts report. Nowhere to go: maternity care deserts across the US. 2022 report. Accessed October 30, 2025. www.marchofdimes.org/maternity-care-deserts-report-2022
13. Rosenberg J. Physician shortage likely to impact OB/GYN workforce in coming years. American Journal of Managed Care. September 21, 2019. Accessed October 30, 2025. www.ajmc.com/view/physician-shortage-likely-to-impact-obgyn-workforce-in-coming-years
14. Society of Teachers of Family Medicine. Core outcomes, competencies, subcompetencies, and milestones. Accessed October 30, 2025. www.stfm.org/teachingresources/resources/cbme-toolkit/epascompetenciesmilestones/overview/
15. Accreditation Council for Graduate Medical Education (ACGME). ACGME program requirements for graduate medical education in family medicine. Revised September 3, 2025. Accessed October 30, 2025. www.acgme.org/globalassets/pfassets/programrequirements/2025-reformatted-requirements/120_familymedicine_2025_reformatted.pdf
16. American Academy of Family Physicians (AAFP). Cesarean delivery in family medicine (position paper). Accessed October 30, 2025. www.aafp.org/about/policies/all/cesarean-delivery-family-medicine.html
17. Kelly BF, Sicilia JM, Forman S, et al. Advanced procedural training in family medicine: a group consensus statement. *Fam Med.* 2009;41(6):398-404.
18. Heider A, Neely B, Bell L. Cesarean delivery results in a family medicine residency using a specific training model. *Fam Med.* 2006;38(2):103-109.
19. Roskos SE, Barreto TW, Phillips JP, et al. Maternity care tracks at US family medicine residency programs. *Fam Med.* 2021;53(10):857-863.
20. AAFP. Fellowship directory. Accessed October 30, 2025. www.aafp.org/medical-education/directory/fellowship/results
21. Loeven M. Credentialing family physicians who provide maternity care. *Am Fam Physician.* 2022;105(5):456-457.
22. AAFP. How to obtain credentials and privileges. Accessed October 30, 2025. www.aafp.org/family-physician/practice-and-career/managing-your-career/scope-of-practice/privileging-and-credentialing/steps-to-hospital-credentialing.html
23. AAFP. AAFP-ACOG joint statement on cooperative practice and hospital privileges. Accessed October 30, 2025. www.aafp.org/about/policies/all/aafp-acog-joint-statement.html
24. AAFP. Privileging, family medicine policy. Accessed October 30, 2025. www.aafp.org/about/policies/all/fammed-privileging.html
25. Pelletier S, Sheff RA, Cairns CS. *Core Privileges for Physicians: A Practical Approach to Developing and Implementing Criteria-based Privileges*. 5th ed. HCPro Incorporated; 2010.
26. Homan FF, Olson AL, Johnson DJ. A comparison of cesarean delivery outcomes for rural family physicians and obstetricians. *J Am Board Fam Med.* 2013;26(4):366-372.
27. Avery DM, Graettinger KR, Waits S, et al. Comparison of delivery-related complications among obstetrician-gynecologists and family physicians practicing obstetrics. *Am J Clin Med.* 2014;10(1):16-19.
28. Aubrey-Bassler K, Cullen RM, Simms A, et al. Outcomes of deliveries by family physicians or obstetricians: a population-based cohort study using an instrumental variable. *CMAJ.* 2015;187(15):1125-1132.
29. Walter G, Jetty A, Topmiller M, et al. Family physicians provide maternity care in and around the maternity care shortage areas, particularly rural. *J Rural Health.* 2024;40(4):664-670.
30. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q.* 2005;83(3):457-502.
31. Pass W. Family medicine–led obstetric units achieve lower C-section rates, better safety culture. Accessed October 30, 2025. https://community.the-hospitalist.org/content/family-medicine-led-obstetric-units-achieve-lower-c-section-rates-better-safety-culture
32. Iobst SE, Storr CL, Bingham D, et al. Variation of intrapartum care and cesarean rates among practitioners attending births of low-risk, nulliparous women. *Birth.* 2020;47(2):227-236.
33. Partin M, Sanchez A, Poulson J, et al. Social inequities between prenatal patients in family medicine and obstetrics and gynecology with similar outcomes. *J Am Board Fam Med.* 2021;34(1):181-188.

34. Avery DM, Burgess K, McDonald JT, et al. Neonatal outcomes of 26,331 infants delivered by obstetrics fellowship trained family physicians and OB/GYNs. *J Fam Med Dis Prev.* 2015:1-3.
35. Kidd M, Avery S, Duggan N, McPhail J. Family practice versus specialist care for low-risk obstetrics: examining patient satisfaction in Newfoundland and Labrador. *Can Fam Physician.* 2013;59(10):e456-61.
36. Coffman M, Wilkinson E, Jabbarpour Y. Despite adequate training, only half of family physicians provide women's health care services. *J Am Board Fam Med.* 2020;33(2):186-188.
37. Quinlan JD. The role of the family physician in rural maternity care. *Clin Obstet Gynecol.* 2022;65(4):801-807.
38. Peterson LE, Blackburn B, Phillips RL Jr, et al. Structure and characteristics of family medicine maternity care fellowships. *Fam Med.* 2014;46(5):354-359.
39. Young RA. Maternity care services provided by family physicians in rural hospitals. *J Am Board Fam Med.* 2017;30(1):71-77.
40. Barreto T, Jetty A, Eden AR, et al. Distribution of physician specialties by rurality. *J Rural Health.* 2021;37(4):714-722.
41. Deutchman M, Macaluso F, Bray E, et al. The impact of family physicians in rural maternity care. *Birth.* 2022;49(2):220-232.
42. KFF. Births financed by Medicaid by metropolitan status. 2023. Accessed October 30, 2025. www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/
43. Stange KC, Miller WL, Etz RS. The role of primary care in improving population health. *Milbank Q.* 2023;101(Suppl 1):795-840.
44. Spiess S, Owens R, Charron E, et al. The role of family medicine in addressing the maternal health crisis in the United States. *J Prim Care Community Health.* 2024;15:21501319241274308.
45. Welsh S, Salazar-Collier C, Blakeslee B, et al. Comparison of obstetrician-gynecologists and family physicians regarding weight-related attitudes, communication, and bias. *Obes Res Clin Pract.* 2021;15(4):351-356.
46. Walters D, Gupta A, Nam AE, et al. A cost-effectiveness analysis of low-risk deliveries: a comparison of midwives, family physicians and obstetricians. *Health Policy.* 2015;11(1):61-75.
47. Coco A. How often do physicians address other medical problems while providing prenatal care? *Ann Fam Med.* 2009;7(2):134-138.
48. Doeksen GA, Schott V. Economic importance of the health-care sector in a rural economy. *Rural Remote Health.* 2003;3:1-6.
49. Avery DM Jr, Hooper DE, McDonald JT Jr, et al. The economic impact of rural family physicians practicing obstetrics. *J Am Board Fam Med.* 2014;27(5):602-610.
50. Weidner AKH, Phillips RL, Fang B, et al. Burnout and scope of practice in new family physicians. *Ann Fam Med.* 2018;16(3):200-205.
51. Barreto TW, Eden A, Brock A. The impact of practicing obstetrics on burnout among early-career family physicians. *Fam Med.* 2020;52(6):408-413.
52. Park CY, Driver N, Richards Jr RC, et al. The effects of CenteringPregnancy: a quasi-experimental evaluation. *Healthcare (Basel).* 2025;13(9):1052.
53. AAFP. How to handle a hospital privilege dispute. Accessed October 30, 2025. www.aafp.org/family-physician/practice-and-career/managing-your-career/scope-of-practice/privileging-and-credentialing/avoiding-a-hospital-privilege-dispute.mem.html

Supported by an educational collaboration with the American Board of Family Medicine (ABFM) Foundation. This partnership reflects the shared commitment to supporting family physicians with practical tools for credentialing and privileging. | DPA250810234