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From passion to practice: clinician teachers' insights on family medicine obstetrical care

De la passion à la pratique : perspectives des enseignants cliniciens sur les soins obstétricaux en médecine familiale

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Abstract

Background: Declining numbers of family physicians (FPs) provide obstetrical care—an essential service. Exploring reasons why current family medicine obstetrics (FM-OB) clinician teachers chose this field and what motivates them to continue may inform retention strategies and inspire future family medicine learners. Our objective was to explore perspectives of academic FPs who practice FM-OB with the goal of increasing recruitment of future FM-OB practitioners and retention of those currently practicing FM-OB.

Methods: Academic FP clinician teachers from three urban multidisciplinary Canadian centers who currently practice FM-OB and deliver at one hospital participated in 60-minute, semi-structured interviews. Questions explored participant experiences providing FM-OB care. Interviews were audio-recorded, transcribed and analyzed using a constant comparison method of descriptive thematic analysis.

Results: There were 10 participants. The data revealed an overarching theme highlighting three key influences on the decision to start and continue practicing FM-OB: 1) Individual; 2) Interpersonal, and 3) Systemic influences. Early experiences with positive feedback, hands-on skills, and positive role models shaped their decisions to start. The joy derived from this work, mentorship, patient relationships, and a supportive environment fueled their commitment to continue practicing.

Conclusion: This study highlights the importance of early learning experiences, effective role models, and supportive systemic factors in encouraging trainees to practice FM-OB and retaining FPs in this field. By also identifying the sources of joy in FM-OB and promoting work-life balance, these findings can help inform programs to retain FM-OB providers and inspire future family medicine learners.

Résumé

Contexte : Le nombre de médecins de famille (MF) qui fournissent des soins obstétricaux, un service essentiel, est en baisse. Explorer les raisons pour lesquelles les enseignants cliniciens en médecine familiale obstétricale (MFO) ont choisi ce domaine et ce qui les motive à continuer peut éclairer les stratégies de rétention et inspirer les futurs étudiants en médecine familiale. Notre objectif était d'explorer les perspectives des MF universitaires qui pratiquent la MFO dans le but d'augmenter le recrutement de futurs praticiens en MFO et de retenir ceux qui pratiquent actuellement la MFO.

Méthodes : Des cliniciens enseignants MF universitaires issus de trois centres multidisciplinaires urbains canadiens qui pratiquent actuellement la MF-OB et pratiquent des accouchements dans un hôpital ont participé à des entretiens semi-structurés de 60 minutes. Les questions portaient sur les expériences des participants en matière de soins MF-OB. Les entretiens ont été enregistrés, transcrits et analysés à l'aide d'une méthode de comparaison constante d'analyse thématique descriptive.

Résultats : Il y avait 10 participants. Les données ont révélé un thème général mettant en évidence trois influences clés sur la décision de commencer et de continuer à pratiquer la médecine familiale et obstétricale : 1) les influences individuelles ; 2) les influences interpersonnelles ; et 3) les influences systémiques. Les premières expériences positives, les compétences pratiques et les modèles de rôle positifs ont influencé leur décision de commencer. La joie tirée de ce travail, le mentorat, les relations avec les patients et un environnement favorable ont alimenté leur engagement à continuer à pratiquer.

Conclusion : Cette étude souligne l'importance des expériences d'apprentissage précoces, des modèles de rôle efficaces et des facteurs systémiques favorables pour encourager les stagiaires à pratiquer la médecine familiale et obstétricale et retenir les médecins de famille dans ce domaine. En identifiant également les sources de joie dans la médecine familiale et obstétricale et en favorisant l'équilibre entre vie professionnelle et vie privée, ces résultats peuvent aider à élaborer des programmes visant à retenir les prestataires de médecine familiale et obstétricale et à inspirer les futurs étudiants en médecine familiale.

Background

Family Physicians (FP) play an important role in providing integrated, comprehensive care to pregnant people and their families throughout their lives.[1] Annually Canadian FPs deliver 14.6% of Canada's newborns,[2] while American FPs deliver 10% of US newborns.[3] However, the number of FPs practicing obstetrical care is declining, putting these vital services at risk.[4] As more FPs retire or discontinue intrapartum care, the overall number of babies delivered by FPs will fall.[1] Mothers who deliver with FPs report being satisfied and having expectations met by their care.[5,6] In comparable low risk patients, FPs have been shown to have lower intervention rates with equivalent or better outcomes compared to obstetricians.[7,8] Moreover, in rural areas, where pregnant people face disparities in access to pregnancy care, 17% travel on average two hours to give birth. These patients are more likely to deliver with a FP compared to those living in urban areas (44.8% versus 26%) due to limited access to obstetricians and greater reliance on FPs to provide comprehensive care in rural settings.[9]

Family physicians who practice family medicine obstetrics (FM-OB) describe satisfaction and generally good quality of life.[10] However, despite the College of Family Physicians of Canada (CFPC) mandate that resident graduates have competency in full scope pregnancy care and the CFPC reporting nearly 36% of graduating residents from 17 Canadian medical schools stated they were "somewhat or highly likely" to practice intrapartum care, recent reports indicate a downward trend in the number of residents who continue to practice FM-OB post-graduation.[11] Although the initial expressed intent is encouraging, it does not guarantee that they will provide this service. In the United States, 21% of new family medicine graduates intend to include obstetrics in their practice; however, only 7% currently do so.[3] Not only are fewer learners choosing to pursue intrapartum care, on a broader scale, fewer students are choosing family medicine as their first choice of residency practice.

Solutions to increase interest in FM-OB remain elusive due to the diversity of contributing factors, including lack of experiences with maternity care in training, low learner confidence, potential for adverse obstetric outcomes, office disruption, lifestyle concerns, lack of positive physician role models, and fear of burnout.[8,10,12] An additional consideration is the structure of FM-OB call systems, which can significantly impact physician workload and job satisfaction. Hard call refers to a structured, scheduled system where FM-OB physicians take designated shifts covering labour and delivery, attending to any labouring patients within the service regardless of prior prenatal care. This model ensures 24/7 coverage and helps distribute workload more evenly among practitioners. In contrast, soft call operates on a continuity-of-care model, where FM-OB physicians are called in when their own patients—those they followed throughout pregnancy—go into labour. While this fosters strong physician-patient relationships, it also results in unpredictable hours, as physicians must be available outside of structured shifts while balancing clinic work and other responsibilities. The differing demands of hard and soft call may influence physician interest in FM-OB and contribute to concerns about burnout and lifestyle sustainability.

Identifying current FPs at diverse career stages who are inspired by their FM-OB work and exploring what led them to that point and how they maintain their interest, is imperative to inspire future generations of FPs and counterbalance the anecdotes of burnout and pressures of administrative burdens. To date there has been minimal exploration of clinician teachers' perspectives among those practicing and teaching FM-OB in an academic center. What is known is that challenges of low teaching confidence and difficulties with learners[13] may play a role in teacher retention. FP clinician teachers offer the perspective of both teaching and clinical roles.

Our explorative qualitative study[14] examines the experiences of FM-OB clinician teachers at an urban centre. We investigate FM-OB clinician teacher experiences that contribute to the decision to practice and continue to practice FM-OB. Findings aim to improve practice and inspire new generations of FM-OB practitioners to counteract the diminishing numbers of those practicing in this important field.

Methods

Study design

In this exploratory qualitative study,[14] we investigated the experiences of FM-OB clinician teachers practicing intrapartum care in a large FM-OB call group in an urban academic teaching hospital. Pulling from social constructivist theory[15] and applying a qualitative research study design,[16] we drew on faculty members' lived experiences as clinicians and educators to develop recommendations based on what drives them to participate and stay in involved in FM-OB. We obtained Research Ethics Board approval (20-0057-E).

Participants

We asked FM-OB clinician teachers (*N* = 30) from three different urban teaching hospitals providing intrapartum

care as a single call group at one hospital to participate in this study. Members of this group deliver approximately 600 babies and train approximately 70 family medicine residents per year.

In this care model, 23 FPs share a "hard call" system with scheduled shifts to attend patients' labours and births. Seven "soft call" FPs take part in the call schedule in addition to personally attending births for their own patients when possible. All members of this group, except project team members (SKo, AB), received an email with a short project description and invitation to participate. Two weeks later, we emailed the faculty a more complete study description and consent form and again invited them to participate. The study's research assistant (RA) (JB) contacted those responding positively to determine a mutually convenient time for a phone interview. Implied consent was obtained.

Data collection

Audio-recorded, 30-60-minute, semi-structured telephone interviews explored participant experiences and perceptions of FM-OB care as we aimed to answer: What factors contribute to FM-OB clinician teacher satisfaction and retention and what factors impact residents' decisions to practice FM-OB.

The RA has extensive experience conducting qualitative interviews. We based the interview guide on the literature and team expertise (Appendix A). JB administered a brief demographic questionnaire to each participant to investigate how lifestyle and demographic factors potentially contributed to participants' experiences practicing FM-OB. The interviews were transcribed verbatim, JB verified and de-identified the interviews.

Data analysis

We used questionnaire responses to describe participants and contextualize interview data. We analyzed interview findings independently by the investigators using a constant comparison method of descriptive thematic analysis.[16] As interview transcripts became available, the principal investigator (PI) (SKo) and RA (JB) created preliminary codes, grouped them into categories, and constructed themes from the categories. We circulated transcripts amongst the other research team members, and together the PI and RA periodically presented their preliminary analyses at research team meetings with the goal of achieving coding consensus. These iterative meetings provided a lively forum where team members suggested further lines of inquiry in upcoming interviews. We discussed the opinions of project team members currently practicing FM-OB (SKo, AB), medical educators (SKo, AB, JC, CW, JNY), qualitative researchers (JNY, AB, JC, JB, SKo, CW), and we documented analytic decisions. The RA (JB) finalized the codebook to reflect all transcripts.

Findings

Of 10 participants consenting to interviews, nine completed the pre-interview questionnaire, (Table 1) and all were between the ages of 30-50. The majority practiced hard call with set call days (*n* = 7, 77.8%) and had a partner (*n* = 7, 77.8%) and children (*n* = 6, 66.7%). Most had been in clinical practice for more than 10 years (*n* = 6, 66.7%) and practiced FM-OB for greater than 10 years. Table 1 shows other participant characteristics.

Table 1. Demographic data of study participants

Participant Characteristics	Interview Participants *N*(%)
Age	
30-40	4 (44.4%)
41-50	5 (55.6%)
Practice Type	
Hard Call[a]	7 (77.8%)
Soft Call[b]	2 (22.2%)
Years in Clinical Practice	
<= 10	3 (33.3%)
> 10	6 (66.7%)
Years practicing FM-OB	
<=10	3 (33.3%)
>10	6 (66.7%)
Years in Teaching	
<= 10	3 (33.3%)
>10	6 (66.7%)
Relationship Status	
Single	2 (22.2%)
Partner	7 (77.8%)
Has Children	
No	3 (33.3%)
Yes	6 (66.7%)

[a]Provider participates in scheduled call shifts for intrapartum care ranging from 12-24 hours.
[b]Provider takes part in call schedule in addition to personally providing intrapartum care for their own patients.

To better understand why these participants started practicing FM-OB and why they continued to do so, three main themes emerged: 1) Individual; 2) Interpersonal, and 3) Systemic influences.

I. Individual Influences

To start practicing FM-OB

Participants described personally important influencing factors early in their training that led them to pursue FM-OB in their careers, including receiving early experiences with intrapartum care, participation in hands on skills and receiving personalized positive feedback about their intrapartum care. These factors piqued their interest in FM-OB, sparked joy and enthusiasm in the discipline, and

helped them develop confidence and competence in their skill set.

Early experiences with and participation in hands-on skills. Participants described being motivated early on in their training by opportunities to actively participate in FM-OB and hands-on patient care. These experiences allowed them to develop their skills, their joy for the work, and their confidence. One participant explained,

> *To be honest, when I was in medical school I did not like obstetrics at all. There was no exposure to do anything hands on. [In residency] I did my first month with the obstetrical team …the chief was incredible. He included me in everything, allowed me to do things, which is I think what made a difference. And I suddenly found this new love for it. And then when I did my second month I was like, 'Yeah, I really love this.'"(P24)*

Positive feedback. Receiving early, positive, and personalized feedback from supervisors when they were learners contributed to participants' choosing to practice FM-OB. One described not only receiving positive feedback on their skill set, but encouragement at an early stage in their training to think about types of experiences that practicing FM-OB would provide. This encouragement allowed them to imagine incorporating FM-OB into their career:

> *Again, [FM-OB provided] that bigger community that as a family doctor, you may not get. For myself, it was something that I also got good feedback around as I was doing my residency. Like, "Oh, you're pretty good at this. Do you like it? What do you think?" ...I think it was that combination of OK, I'm enjoying it. I seem to be good at it. It would provide me those different types of work experiences that I won't get otherwise in a team setting and the hospital. (P22)*

To continue practicing FM-OB

Variety in clinical practice. Participants appreciated the variety FM-OB brought to their clinical practice. Providing different types of care experiences and the opportunity to provide support across all facets of patients' lives was important professionally:

> *The thing that really appeals to me as well as having prenatal patients within my family practice and just like at my core, I'm a family physician. That's what I'm passionate about. And so this idea of variety and of being able to provide care in all parts of life is really of value to me from a professional identity perspective. (P11)*

II. Interpersonal Influences

To start practicing FM-OB

Interaction with effective role models. Participants described how interactions with effective role models early on in their training strongly influenced them to go into FM-OB. They observed that the joy these faculty had for the discipline motivated them to include FM-OB in their future practice. One explained, "I had good role models who essentially modelled the benefits and the joy that it can give you. And so I think with a little bit of a nudge and a push from supervisors and role models, that sort of got me more interested." (P28)

To continue practicing FM-OB

Several other interpersonal influences emerged as participants described reasons why they continue to practice FM-OB, including the joy they experienced working with learners and forming longitudinal relationships with patients.

Joy working with learners. These clinician teachers described the joy and rewards of working with learners and watching them progress as motivators to continue practicing FM-OB:

> *I love the relationships with the students and the residents... It's really delightful when you can help someone grow. First of all, you get to see them over time. So you get to see where they started and where they ended, and that's really rewarding. But even just in the moment, it's nice when you can work with someone and give them a new piece of knowledge, or a new piece of skill that maybe they didn't have before, or a new perspective, a new way to think about things, and have those conversations. (P11)*

Longitudinal relationships with patients. Study participants also continued to practice FM-OB for the satisfaction of establishing longitudinal relationships with patients and their families. They recognized the importance of a FP who provides care to people not only during the intrapartum and postpartum period but throughout the entire lifecycle:

> *The other part I thought was just a really nice combination because my own patients in family medicine would become pregnant…I would follow them and then I'd deliver them potentially if I happen to be on call, and then I would take their baby on into my practice. I just love the continuity and the ability to see them prior to pregnancy, during pregnancy, labour and delivery, and then take care of their babies. And I just like that aspect of it, and I feel like it's so fluid that I can go back and forth to OB to family very easy*

because my practice has a lot of kids in it. I just enjoy that part of it. (P24)

III. Systemic Influences

To continue practicing FM-OB

Participants credited several parts of the larger system in which they work as important influences that enabled them to continue practicing FM-OB. These factors included a collegial team environment, strong leadership and a supportive call group. A collegial team environment was situated under the Systemic theme because institutional structures and policies were described as actively fostering this environment. Rather than emerging solely from individual or interpersonal dynamics, the collegiality described by participants was supported by the way the system was organized—through scheduling models, interdisciplinary collaboration, and institutional culture. Highlighting this as a systemic factor is particularly important for understanding how to replicate and promote supportive FM-OB environments in other settings.

Collegial team environment. Respondents expressed gratitude for the system in which they worked. During challenging times such as the COVID-19 pandemic, a collegial environment helped them to continue practicing FM-OB. As one respondent commented, "I also think our program is very collegial. We're very supportive of each other. We help each other when we need. And we're quite understanding of personal circumstances. And I think COVID particularly highlighted that." (P28)

Strong Leadership. Many individuals and teams including nurses, FPs, obstetricians, administrators, clerical staff and learners work alongside one another while providing care on a labour and delivery floor. To work effectively together, strong leadership is needed. Our participants credited leadership from each of these teams and felt their interests and concerns were well represented, enabling them to continue to practice FM-OB: "There's [sic] good leadership structures that help make decisions effectively that represent all the stakeholders… it just feels nice to be part of that system where I feel like people care. They're all trying to do the right thing."(P22)

Supportive call group. Maintaining work life balance was also an important consideration for participants. Call models were significant in both deciding to do FM-OB and being able to continue practicing it while balancing professional and personal commitments.

The lifestyle piece for me is the biggest part of the hard call system … different people manage that anxiety differently, but for me, it would be total game-changer. I think I would just be too anxious to manage that sort of possibility being called in at any time. (P21)
Another participant felt the hard call system was essential to practice FM-OB. "…I'm hard call. …I don't think I would do family medicine if I was soft call to be honest. … I know when I'm on call, and I put my phone away when I'm not on call. …It's just easier to plan. (P24)

Discussion

As the number of FPs providing intrapartum care declines,[1,17] there may be decreased patient access to perinatal care in some locations—particularly rural and remote areas. Intervention in FM-OB training programs is key to retaining this essential health care service. In this study, we explored the influences on FM-OB clinician teachers, examining the motivational factors that initially drew them into the field and what sustains their practice. Specifically, we asked what factors contribute to their satisfaction and what factors they view as impacting residents' decisions to practice FM-OB. We identified influences at the individual, interpersonal and systemic levels, which may inform strategies to enhance the retention and advancement of FM-OB care within family medicine.

Participants were drawn to FM-OB early in training if they were influenced by positive reinforcement, early experiences that enhanced skills and confidence, and interactions with effective role models—a finding that also supported by other studies.[18] For example, to address declining medical student interest in surgical specialties, some medical schools increased experiences by offering specialized courses and faculty mentorship, which led to increased student interest in these fields. Participants in these programs indicated major reasons for continued interest in surgical specialties were opportunities to practice procedures early and mentorship from faculty.[19,20] Providing learners with opportunities for FM-OB skill development and confidence building, reinforcing their aptitudes, and exposing them to positive role models may positively influence their future career paths. These influences are most impactful when introduced in medical school or early in residency, as demonstrated by our study participants. This study's findings also provide insights for clinician teachers. By understanding the factors that influenced participants to choose FM-OB, clinician teachers can gain valuable insights on how to effectively mentor and guide learners, thereby potentially increasing engagement and attracting more learners to FM-OB.

FM-OB is often perceived as bringing joy and clinical variety to a practice, both of which are believed to provide a protective effect against burnout.[12,21] Joy also emerged as a sustaining element in providing FM-OB care in this study, again possibly preventing burnout. Our participants found particular joy and personal satisfaction in teaching learners, including observing their application of newly achieved skills and evolution over time. Facilitating clinician teachers' reflection on what brings them personal fulfillment and joy is vital, for example in helping them recognize the positive influences of their relationships with learners and patients. Creating an environment that values and supports self-reflection can significantly enhance FP satisfaction and retention, protect against physician burnout, and enhance professional commitment.[22]

Physician well-being has far-reaching effects, impacting both patients and healthcare delivery systems.[23] During these challenging times, family medicine is being tested at all levels and supports are needed to facilitate the clinician teacher's joy, growth, and wellness. Examples include mindfulness-based interventions, space to increase physical activity, and health coaching.[24] Additionally, our study identified institutional features, including a supportive atmosphere, effective leadership, and flexible call groups as key systemic motivators for participants, aligning with existing literature on factors facilitating the integration of FM-OB into practice.[25]

Study participants also noted that a supportive call group and strong leadership helped them sustain work life balance. Previous research has shown the work system plays an integral part in career longevity for those practicing FM-OB.[26] Our participants underscored that the presence of a collegial team environment was an essential factor contributing to their sustained practice in FM-OB. They highlighted the significance of an interprofessional clinical team for fostering collaboration, a factor they found instrumental in their continued commitment to practicing FM-OB. The concept of *joy in work* includes how the impact of who we work with and the work we do can increase happiness in the clinical setting.[27]

Of note, this study was conducted during the COVID-19 pandemic. During the pandemic physicians reported increased burnout due to restriction of activities that enhanced their wellness and compromised physician patient relationships due to social distancing.[28,29] To counteract burnout, recognizing vulnerability to stress, setting boundaries and reengaging in personal joys post-pandemic are crucial.[30] As health care professionals return to a level of normalcy after years of stoic behaviours and working long hours, physicians including FPs practicing FM-OB, should be encouraged to reengage with the people and activities that bring them joy. Promoting self-care such as regular exercise, healthy eating and adequate sleep is one strategy to help support FPs in managing the demands of the profession. Additionally, providing access to supportive resources such as stress management workshops could be beneficial. However, relying primarily on personal efforts for well-being places undue burden on FPs. The participants in this study emphasized the critical role of strong leadership and supportive teams in their ability to continue practicing FM-OB and find joy in their work. Systemic changes such as fostering effective leadership, creating collaborative work environments and addressing organizational inefficiencies may also help reduce burnout and help individual physicians manage their own stress.

While not every family physician finds joy in intrapartum care, this study offers insights into the motivations, rewards and challenges faced by those who do, particularly amid increased burnout and declining interest in family medicine. Identifying joyful FPs, understanding their sources of fulfillment and what keeps them engaged and inspiring future generations becomes crucial in the current climate. Administrators may use these insights from FM-OB practitioners to develop institutional and systemic solutions that address workload pressures, emotional fatigue and other contributing factors leading to practice cessation and attrition within family medicine.

A limitation to our study findings is that they are from a single urban academic program. FM-OB providers may face different challenges in rural and non-academic settings. For example, rural MDs are more likely to be in private or solo practice[9] than those in urban centres, which would impact the types of individual, institutional, and systemic issues that they would face. Future research should aim to expand the scope of inquiry to include FM-OB providers in rural, community-based, and non-academic settings. Comparative studies between urban and rural practitioners could provide insights into how different practice environments influence motivations to enter and remain in FM-OB. Additionally, longitudinal studies tracking changes in motivations over time, particularly in relation to evolving healthcare demands and work-life balance, may offer a deeper understanding of factors contributing to both retention and burnout in this specialized field. Despite this limitation, we provide novel insights into the motivations of FP clinician teachers practicing FM-OB.

Conclusion

This study offers insights into how FP academic faculty can encourage trainees to choose to practice FM-OB, and the factors enabling FPs to enjoy and continue to practice FM-OB. Early experiences and encouragement, effective role models and recognition of the inspiring sources of joy in FM-OB practice and teaching are crucial. Additionally, supportive systemic factors such as prioritizing strong leadership and cultivating cohesive and supportive team dynamics that enable personal life balance are essential for maintaining the FM-OB care model. As the number of FPs providing intrapartum care decreases and family medicine as a specialty continues to face recruitment challenges, it is crucial that those providing this essential and special service through the lifespan are retained. This study's findings may help inform other programs how to better ensure retention of FM-OBs and inspire future learners to choose family medicine as a career.

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Appendix A. Interview guide: family physician faculty questions

Four sections based on following:

I. FP faculty experience practicing FM-OB

II. Role as teacher

III. Strengths of program vs. what needs improvement

IV. How to retain those currently practicing and recruit more residents to the field

I. Perceptions of FM-OB at MSH

1. Tell us about your experience practicing FM-OB

2. Can you describe why you decided to include family medicine obstetrics in your practice? When did you make this decision?

Prompt: What happened at this time? Any mentors that helped you?

3. What do you enjoy about doing FM-OB?

Prompt: - Do you feel you are currently participating in adequate number of deliveries and procedures (artificial rupture of membranes, Foley catheter insertion, Cervical exams, Vacuums) to maintain competence?

4. What do you not enjoy about doing FM-OB?

5. How is your life affected by doing FM-OB?

Prompt: Personal and Professional life- Does practicing FM-OB interfere with other professional goals i.e. Research, education scholarship, other professional opportunities.

Now we want to focus more on your satisfaction and retention:

6. What type of call do you do?

7. Tell us about the type of call you are involved in now? What are other models have you practiced in in the past or seen or heard about? What do you think works best?

8. What keeps you satisfied doing this type of work?

9. Why do you keep practicing FM-OB?

10. Do you see yourself continuing to be a member of the MSH FM-OB care model in 5 years? In 10 years? Why? Are you still do maternity care? Do you see yourself still teaching?

II. Role as teacher

Now we would like to switch gears and discuss your role as teacher

1. Please tell me about your experiences teaching FM-OB?

2. What do you enjoy about teaching in the FM-OB care model? Give examples

3. What do you not enjoy about teaching in the FM-OB care model? Give Examples

4. How does the maternity care program (learning and teaching environment) impact your teaching and resident learning?

III. Strengths of program vs what needs improvement

Now we would like to thoughts on the program can improve

1. How do you feel we are doing as a program (learning and teaching environment) with resident teaching? What works well, what works less well?

Prompt: How can the department better support maternity care teaching? What would help you develop your teaching skills in FM-OB?

2. Do you have any concerns about the residents' FM-OB learning experience?

Prompt: Strengths of teaching model? Enough exposure to develop their skills?

IV. How to retain those currently practicing and recruit more residents to the field

Now we would like to get your thoughts on how to ensure retention of both staff and future graduates.

1. With the current numbers of Canadian FM-OBs declining any suggestions on how we can ensure our current faculty continue to practice FM-OB? What are limiting factors?

2. What factors from the learning environment impact residents' decision to incorporate FM-OB into their future practices?)

3. Any suggestions on how to motivate FP residents to continue practicing intrapartum care after graduation? What are the limiting factors?

4. Any final thoughts?