

harmonization between breastfeeding policies and support across hospitals where a woman received postpartum care, which could be addressed in future study design.

To our knowledge, there is sparse evidence that reports the association between mode of conception and breastfeeding practices in the United Kingdom. Despite the study's limitations, Barrera et al offered important insights into breastfeeding outcomes in women who conceived via assisted conception that raise the opportunity for intervention and support for breastfeeding in this cohort of women. Further longer term studies are necessary to investigate factors that influence breastfeeding initiation and continuation by mode of conception, taking into account the limitations that we have discussed. ■

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The authors report no conflict of interest.

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Improving treatment of opioid use disorder in pregnancy: first define the workforce



TO THE EDITORS: As Hollander et al¹ report, the maternity care workforce in the United States has not adapted to care adequately for the growing number of pregnant women with opioid use disorder. We agree that obstetric providers could help fill a gap in opioid treatment during pregnancy, particularly in rural areas. However, we would like to draw attention to the problem of lumping a diverse group of medical specialties and provider types into a broad “primary care” category.

First, this analysis does not differentiate important players in the maternity care workforce. Lumping family physicians with other primary care specialties in an analysis focused on the care of pregnant women with opioid use disorder discounts the contributions of family physicians who provide maternity care. Family medicine is the only 1 of these primary care specialties that is trained in both prenatal care and obstetrics.

Second, lumping all primary care providers, but not all obstetric providers, confuses the issue. “Medical specialty” implies those trained in medicine (ie, physicians); “providers” indicates a broader group of clinicians who practice in a discipline. Certified nurse midwives (CNMs) should be included as obstetric providers, because they are growing in number and their eligibility to obtain a waiver could help to address the care gap. Buprenorphine waiver training is newly available for nurse practitioners (NPs), physician assistants (PAs), and CNMs, although longer and more intensive than for physicians; independent prescribing is limited in some states.² A more apt analysis would compare those clinicians (obstetrician/gynecologists, family

physicians, and CNMs) who provide obstetrics care with those who do not.

Finally, family physicians provide the majority of rural healthcare, including maternity care.³ Lumping family physicians with general practitioners, internal medicine, and pediatrics masks their rural impact. In 1 small study, family medicine was the most common specialty to prescribe buprenorphine in rural areas⁴; pediatricians, internists, and obstetricians/gynecologists are less common in these locations.³

To expand care for pregnant people with opioid use disorder, we should begin by supporting family physicians, CNMs, NPs, and PAs who are already providing these services in rural and underserved communities. The maternity care workforce, which includes obstetricians/gynecologists, family physicians, midwives, NPs, and PAs, should work together to increase access to adequate high-quality care to pregnant and postpartum women with opioid use disorder in all geographic settings. Increasing the number of maternity care providers with buprenorphine waivers would begin to address access to treatment. ■

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REPLY



We thank Eden et al for their letter regarding an oversimplification of the medical specialties categorized as primary care in our analysis. We agree that family medicine physicians, certified nurse midwives, and advanced practice providers are important providers of maternity care services, especially in rural settings, and play a critical role closing both the maternity and substance use treatment gap for pregnant and postpartum women.

The proportion of family medicine providers providing maternity care has declined steadily over the past decade, and we were unable to account for the provision of maternity care services beyond provider specialty in our analysis.^{1,2} Because of the limitations inherent in our claims dataset, we choose to categorize family medicine providers as primary care providers.

Certified nurse midwives and other advanced practice providers (eg, nurse practitioners) are also important

providers of both maternity care and substance use treatment services, including opioid pharmacotherapy. However, nurse practitioners and physician assistants have only been able to prescribe buprenorphine through the Comprehensive Addiction and Recovery Act since early 2017, and our analysis was limited to data from 2013–2016.³ Thus, we were unable to include the important contribution from advance practice providers in our analysis.

Given that many pregnant women with opioid use disorder continue to lack access to evidence-based medication-assisted treatment, future research is needed to further understand the gaps in the substance use treatment provider workforce including the type, frequency, and quality of clinical care services beyond pharmacotherapy provided by prescribing providers. ■

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Should we absolutely reject the hypothesis that epithelium-based *Candida* biofilms contribute to the pathogenesis of human vulvovaginal candidiasis?



TO THE EDITORS: We read the article by Swidsinski et al¹ with great interest. The authors used fluorescent in situ hybridization of human vaginal tissue biopsies to demonstrate the absence of *Candida* biofilms in patients with vulvovaginal candidiasis (VVC). This is a very important finding because it

might reset the treatment target for recurrent VVC (RVVC) from biotic biofilms to invasive fungi.

However; from the microbiologic aspect, it is reasonable to assume the involvement of *Candida* biofilms in VVC and their resistance to antifungals. Although most clinical isolates