International Perspectives

Obstetrics and the Family Physician: Changing Situations

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The delivering of babies with all its emotional overtones has always been an accepted part of family medicine—after all, families begin with babies. My father's successful family practice 50 years ago was built up largely because of his interest in and success at delivering babies at home. As a medical student I was rather terrified and aghast at his procedures of anesthetizing the mother with chloroform on an open mask and then proceeding to apply forceps, almost by candlelight, at the other end of the woman in labor. It amazed me how he got away with it. And he *did*!

However, the maternal mortality rate was well over 1 for 1,000 and the infant mortality rate was 40 per 1,000 in my father's days. Now in the United Kingdom the maternal mortality is below 0.1 per 1,000 births and the infant mortality rate is close to 10 per 1,000 births.

If the maternal mortality and the infant mortality rates are to be reduced further, then there will need to be considerable effort applied to eliminating all possible risk factors, and, increasingly, obstetrics will become a field of more and more specialization. It is a truism that having a baby is a normal act, but it is true also that it is "normal" only in retrospect, after the event.

Trends and Changes in the United Kingdom

Some remarkable changes have occurred in the United Kingdom over the past 15 years. Home deliveries have almost disappeared. Whereas in 1960 as many as 40 percent of all births were taking place at home, now it is less than three percent. The birth rate has almost halved from 20 to 12 per 1,000. The hospital obstetric beds have only a 66 percent occupancy.

The British general practitioner still is very much involved with obstetrics but with different degrees of involvement. He/she is very much involved in family planning. He makes the diagnosis of pregnancy. He is involved with much of the antenatal care, often shared with the local special obstetric hospital unit. He is involved in postnatal care when the woman comes home after two to three days.

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Table 1. Annual Obstetric Events in Practice Population of 2,500

Total number of births	30
Primipara	12
Application of forceps (the United Kingdom rate is only 10 percent)	3
Cesarean section	1
Infant mortality	1 in 3 years
Maternal mortality	1 in 30 years
Postpartum hemorrhage	3
Antenatal complications	3

In the United Kingdom there is a strong tradition of midwifery, and there are 20,000 trained midwives in our population of 55 million (the equivalent number in United States would be 80,000 midwives). It is these highly skilled midwives who are involved in normal obstetrics. They participate in antenatal care, they carry out normal deliveries, and they supervise postnatal care. They are our specialists in normal obstetrics.

Abnormal obstetrics is a field for the specialist obstetrician. This is largely because of the advances in this field and because anyone accepting responsibilities must have a sufficient number of cases annually to maintain his/her expertise.

Some Facts and Figures

Let us consider what may be the logistical expectations in obstetrics of a British general practitioner. The average size population for which he (88 percent of British general practitioners are men) cares is 2,500 persons. Within this population in any year the events in Table 1 may be expected to take place.

Implications for the Future

If midwives can and do (in the United Kingdom) conduct *normal* deliveries efficiently and safely, and, if specialist obstetricians should be responsible for abnormal pregnancies, what should be the role of the family physician?

This is a nice and delicate question for debate and discussion. We have still many obstetric beds in our National Health Service for the use of family physicians who wish to deliver their own patients, but the numbers are falling and the majority of these, too, are being delivered by midwives.

Qualitative data suggest that when like cases are compared with like, ie, general practice obstetric units with specialist hospital units, the results are better in the latter.

My view, taking the welfare of my patients as the chief criterion, is that there is little place for the family physician in the "partum" phase of obstetrics. The mother should be delivered in a modern hospital unit. Normal deliveries should be conducted by well-trained midwives and abnormal deliveries must be the responsibility of specialist obstetricians.

Paradoxically, there is a growing field for the family physician in sharing in the antenatal care and particularly in preparing and educating the new mother for child care thereafter. In my practice it has become an easy transition from antenatal care, which includes the participation of our practice midwife who will deliver the mother in the hospital and our practice health visitor (public health nurse) who will help the mother with normal child care, to postnatal care and well-baby care thereafter. A good British compromise has been achieved!