Obstetrics and Family Practice: A Positive Perspective

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Every family physician achieves fulfillment in daily practice by emphasizing ongoing personal relationships. Since a belief in this type of fulfillment has been my philosophy since beginning residency in July 1975, it never made much sense to me to limit my practice to people aged over 65 years or under 14 years, male or female, pregnant or nonpregnant. In recent years growing malpractice premiums and a progressively more hectic practice have prompted many family physicians, including me, to re-evaluate the importance of obstetrics in family practice.

The Decision

The decision to do obstetrics in family practice is an affirmation of the specialty itself. A newly graduated medical student who pursues family medicine instead of a more lucrative specialty is generally motivated by a commitment to people and family-centered care, social concerns, and the apparent maldistribution of health resources. Will students of the future opt for family practice if family physicians are excluded from care of the mother, the infant, and the child? Mehl et al[1] compared family practices in the San Francisco Bay area depending on the presence or absence of obstetrics. The groups not practicing obstetrics were found to do acute care primarily, and long-term care to a lesser extent. They were also found to do primarily internal medicine, but very little pediatrics or gynecology. The groups practicing obstetrics did significantly more minor surgery, gynecology, pediatrics, and psychotherapy. This study was critical to shaping my thinking during the formative early years.

Practice Profile

Experience during the last 4 1/2 years in southwest Georgia reflects these findings. Not only does obstetrics vary the age group, but it also affects the practice profile. A woman who receives comprehensive, family-centered, high-quality care during her pregnancy develops a special trust for the person who delivers her baby. This trust grows into similar relationships with her sisters and her cousins, her elderly grandmother with problems owing to polypharmacy and disordered health care, and a skeptical husband who faints during a Lamaze movie, develops Couvade syndrome,[2] or in some cases, an acute abdomen that just might have been overlooked had a relationship with the physician not grown during his wife's pregnancy. Time and time again trust relationships developed during pregnancy translate into third-, fourth-, and fifth-generation families being cared for by the same family physician.

Time Management

One often-voiced criticism of doing obstetrics is a concern over time management. In our daily practices we allow a certain percentage of our time for emergencies. On the average we see 20 to 25 patients per day and have between 3 and 5 patients in the hospital. We manage 6 to 10 deliveries per month in our two-person practice. Our patients are not treated like components on a conveyor belt.

Presented at the Duke-Watts Alumni Symposium, Durham, North Carolina, June 16, 1983. Requests for reprints should be addressed to Dr. Albert A. Meyer, Thomasville Family Medicine Center, 210 West Hansell Street, Thomasville, GA 31792.

Each patient has an average of five concerns ranging from the immediate concern of the day to questions about Grandpa in the nursing home or about a 9-year-old child in the waiting room with a cough and fever. Handling such concerns on a day-to-day basis is challenging, to say the least.

A commitment to be with a woman at 6 cm dilation often means a lost morning or afternoon in the office. In my practice this is a welcome change of pace and an opportunity to energize my empathy battery. It also means diligent rescheduling by the office staff and a move away from demanding, unyielding, antibiotic-seeking patients toward a flexible, understanding, less-rigid patient population, geared more to health maintenance and prevention than to crisis orientation.

The Unique Role of the Family Physician

The family physician is uniquely trained to deal with one of the most sensitive areas in obstetrics, that of the unwanted teenage pregnancy. Often the young woman's last visit to a physician has been to her pediatrician. She is frightened and anxious, and her decision as to a course of action may have been made prematurely by her parents or her boyfriend. The family physician can work with her to explore her options in a nonjudgmental fashion and help transform a potentially devastating situation into a growth-producing experience for all involved.

Fertility is another area in which the family physician can make a unique contribution. Instead of making the woman feel that it is her problem by focusing on her diagnostic workup, the physician can approach infertility as a problem with the relationship, thus allowing both partners to participate in the initial evaluation. In addition, pregnancies complicated by diabetes or hypertension managed by the well-trained family physician and obstetrical colleagues should be studied. Family physicians do have a role in maternal health care, and this option should be more available to the patient population at large.

Practice Fulfillment and Empathy Burnout

Empathy is something that all potential family physicians are filled with as they start medical school. A fine line separates empathy and overidentification. As an empathetic medical student at Downstate Medical School in Brooklyn, New York, I cringed at the thought of opening my cadaver's back, of obtaining blood from a terminally ill cancer patient, or of helping with the closure of a patient's acute abdomen on a busy Kings County Hospital Surgery Service. I have urged the medical students that do preceptorships in our office to identify with the patient, to be a patient advocate, and to listen. Inevitably loss, grief, and disappointment in human relationships occur. I urge medical students to talk these experiences out and not to become devastated. Empathy is something that seems to have a different threshold for use, depending on one's mood, recent losses, and a host of other factors. Physicians sometimes cope with empathy burnout by replacing the *New England Journal of Medicine* with *Medical Economics*, replacing a small, efficient compact with a diesel-powered Mercedes, and human concern for health and wellness with the intellectual chess game of physician vs disease. I try to avoid empathy burnout not by giving obstetrical care alone, but by making a good percentage of my practice health centered, focusing on disease prevention. Fostering maternal health during pregnancy is a good place to begin.

References

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Suggested Reading

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Answers and Discussion

1. All responses are correct. The Canadian Task Force on the Periodic Health Examination[1] includes all these items as appropriate for counseling at the discretion of the physician. Alcohol and tobacco are well-known risk factors for a variety of disorders. Accidents, especially related to the automobile and to occupations, are the leading cause of death until the fifth decade, and are the fourth leading cause (behind heart disease, cancer, and stroke) in overall mortality. Initiating a discussion of family, marital, and sexual concerns allows the patient to bring up problems that might not otherwise be volunteered, despite the high prevalence of dysfunction in these areas.

2. Responses C and D are correct; A and B are false. The diagnosis of glaucoma usually requires elevated intraocular pressure (21 mmHg or greater), cupping and pallor of the optic disc, and visual field defects. A summary of epidemiologic data[2] indicates that only about 10 percent of people with elevated IOP have clinical glaucoma. Up to 20 percent of glaucoma cases occur with normal pressures (usually 17 to 20 mmHg). Campos-Outcalt and Carmichael[2] conclude that routine office screening should be considered only "if a ready, low-cost, and reliable source of visual field testing can be found" to further examine the 5 to 10 percent of patients above the age of 40 years who are likely to have elevated IOP.

3. Responses A, B, and C are correct. Breast self-examination and physical examination will discover at least 50 percent of breast cancers. In the Breast Cancer Demonstration Project,[3] an evaluation of several screening activities, 42 percent of nearly 3,600 breast cancers were detected by mammography alone. The American Cancer Society currently recommends mammography once before the age of 40 years, every year or two until the age of 50 years and then yearly thereafter.[4] The use of mammography should be considered at younger ages when the patient has a family history of breast disease or suspicious physical findings. Unfortunately, the high cost of this procedure may limit routine annual screening to higher risk women only. Ultrasound may be helpful in younger women with more homogeneous breast tissue, but it is not recommended as a routine screening procedure.[5]

4. D is correct. When studied for screening and prognostic value, the routine ECG has not been shown to have general benefits.[6] A study of patients coming for emergency room care for chest pain[6] indicates that the ECGs of 83 percent supplied sufficient information for a diagnosis to render a previously obtained recording superfluous. In 5 percent, equivocal examinations and ECG findings might have been resolved by a baseline ECG, but the authors point out that to be effective the previous tracing should have been available and relatively recent. Published recommendations for periodic screening are divided on the issue of the routine ECG. The Canadian Task Force[1] and Frame and Carlson[7] do not list this procedure, whereas Breslow and Somers[8] and the Institute of Medicine[9] recommend a baseline tracing at about the age of 40 years.

5. D is true. The ranges of normal values for most chemical tests are created from results obtained on normal subjects, that is, individuals with no evidence of clinical abnormalities. The distribution of results of any one test tends to follow a bell-shaped or "normal" curve. Normal values are arbitrarily defined, usually as two standard deviations on either side of the mean value. Approximately 95 percent of values fall in this range; this also implies that 5 percent of clinically well individuals will have results outside these "normal" values. Thus, the probability of an asymptomatic, presumably healthy individual having an abnormal result on any one test will be 5 percent. For multiple tests the likelihood that all will be within the normal range is the product of the individual probabilities, or .95 (.95) . . . or $(.95)^n$, where n is the number of tests. For an 18-test panel, the probability of all results being normal is $.95^{18}$, or .38. Therefore, there is a 62 percent likelihood (1 − .38) that at least that one result will be "abnormal" even if the individual is without disease.[10]

References

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