Family Practice Forum

Obstetrics in Family Practice: Competence, Continuity, and Caring

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In a recent editorial, "Doing Obstetrics: Risky Business,"[1] a young residency-trained family physician suggests that his colleagues consider omitting obstetrical care from their practice in order to transfer the attendant anxieties and risks to a variety of other specialists. Every delivery, he suggests, is of potential high risk and should be attended by an obstetrician and a neonatologist (and perhaps an anesthesiologist) to ensure that the highest level of expertise is always immediately available in case of emergency.

It is our view that obstetrics is central to family practice and that family physicians can and should be trained to provide high-quality care to the majority of pregnant women and their newborns.

The delivery room is not the only setting in which family physicians are required to respond immediately and skillfully to life-threatening emergencies. Such stressful challenges are encountered with cardiac arrest, respiratory failure, and anaphylaxis—perhaps even more often than with obstetrical care. Yet we do not withdraw from the care of patients with chest pain, asthma, or allergy. We adapt in the manner most helpful to our patients, to our community, and to our own piece of mind: we learn expert management, acquire the essential skills, and accept the responsibility to identify and refer those patients whom we can predict may need consultant services.

The current training standards of family practice residencies provide the knowledge and skills that enable graduates to provide high-quality obstetric and newborn care. In addition to routine care, competence in the management of emergency obstetrical and pediatric problems is part of

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standard residency training.

Studies have shown that family physicians can and do provide high-quality care to obstetric patients across a wide spectrum of risk level, achieving maternal and neonatal results comparable with those seen with care by other specialists.[2-5] Studies have further shown that the practices of family physicians who drop obstetrical care soon also lose the care of pediatric, gynecologic, and surgical problems and appear to evolve toward a practice profile more resembling general internal medicine.[6]

Turning obstetric cases over to obstetrician-gynecologists does not guarantee better management of emergency situations in the delivery room. Although obstetrician-gynecologists can perform emergency cesarean sections, they are not necessarily adequately prepared to manage an asphyxiated infant or another neonatal crisis. Pediatricians may be best qualified for critical neonatal care, but they do not provide obstetrical care. Some anesthesiologists are competent in managing the neonatal airway, but do not provide further care or manage maternal complications.

Even when consultation is indicated, continuing care by the family physician insures continuity of care through this important phase of the family life cycle. Clearly each delivery cannot be attended by the full complement of specialists who might have the skills to apply in all conceivable emergencies. Perspective and training enable the family physician to make early identification of special problems and organize the appropriate team members to respond. The demand that these specialists all be present at each delivery would create unacceptable burdens of technology, resource allocation, and cost. Further, many communities across the country do not have, and likely will never have, consultant obstetricians and neonatologists to provide perinatal care to each patient. Those communities will need generalists to provide obstetrical care, and the specialty of family medicine has properly inherited the responsibility to train them.

We are not arguing for the "do all and be all" approach to training family physicians. We have chosen, however, and continue to find professional satisfaction in the "do most and do it right" approach to comprehensive care for our patients. There are procedures that seem appropriate to leave to more limited specialists who can benefit from the higher frequency of performing the procedures. A patient with an inguinal hernia might be better served by having it repaired by a general surgeon who performs four such procedures a week than by an urban family physician who performs only four such procedures a year. That does not argue, however, that the family physician cannot achieve and maintain the same standards in this procedure as does the surgeon. Furthermore, we must recognize that the complementary relationship between family physicians and other more limited specialists rests fundamentally upon the fact that the consultant can develop and maintain the required skills only if most patient care is managed by primary care physicians.

One of our most fundamental responsibilities as family physicians is to recognize our own limitations and learn to help our patients get care beyond our own capabilities. Practicing obstetrics is, and always has been, a highly personal professional decision for many physicians. Despite the highs and lows, the risks and routines, family physicians should not abbrogate their proper role in the delivery of obstetric and newborn care.

References

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