



Training for family practice obstetrics *Let's rethink our approach*

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Family medicine obstetrics seems to be a dying discipline. All current data point to the fact that family doctors are choosing not to do obstetrics and are opting out in increasing numbers.¹⁻³ Yet our training programs continue to offer mandatory obstetric experiences. We need to rethink our approach. We can make changes in how we train future family doctors, which can ensure that we support, sustain, and retain them in their chosen discipline. We can concentrate on those most likely to practise obstetrics, train other family doctors to share care, and build supportive and sustaining clinical models.

For many, family practice obstetrics remains one of the most satisfying and fulfilling aspects of practice. A number of life events have influenced my thinking about this issue: my early years in practice; my developmental years as an academic; and, more recently, my years as chair of one of the 16 departments of family medicine.

Early years

During my early years in practice, I learned that I could be trained to be confident in obstetrics, but that there were also structural problems that made it easy to lose those skills. I also learned I needed greater community understanding about my role and more collegial support.

I did my medical school training in Johannesburg, South Africa, and my internship in Soweto at Baragwanath Hospital. My internship in obstetrics occurred in 1976, following the Soweto riots, during a state of emergency. During those 6 months, all births of more than 2 million people took place at the hospital where I trained. We had more than 80 deliveries a day. My role in the case room as an intern was clearly defined. I assisted in the difficult births only: forceps, vacuum extractions, breech births, and cesarean sections. I was responsible for rescuing any situation that went wrong, such as a shoulder dystocia, a postpartum hemorrhage, eclampsia, and unexpected cesarean sections. I developed a certain

confidence from exposure and experience. When I moved to Canada after my internship, I was thrilled with the idea that I would devote my work life to delivering babies.

Worries and doubts

My first job was in rural British Columbia in 1978. I was a solo GP. I really wanted to attend the births of the patients in my practice (about 10 a year), but the nearest hospital was 55 km away. It seemed that the previous doctor had not included obstetrics in what he offered. I felt intimidated. I wondered whether I should do home births, but I was really too scared that something would go wrong.

I brooded about unexpected postpartum hemorrhages and wondered how I would cope without blood. I thought about precipitated deliveries, prolapsed cords, and unexpected bleeding. I worried about how I would deal with a baby with no vital signs. I knew that most babies delivered themselves. It was the ones that had a problem that were my problem. Even if I did not provide obstetric care (which meant I would soon be out of practice), these unpredictable events would still occur.

There were tremendous additional barriers to my continuing to provide obstetric care: I was alone, and I had no call group. The nearest hospital was more than 1 hour away. I felt terribly unsupported. There was no culture of sharing the burden. I did not think to seek out doctors from nearby towns.

Academic years

When I became a full-time academic family physician at McGill University in Montreal, Que, in 1984, I learned many more important lessons: residents choose whether they want to do obstetrics before they start their residency; role models who love obstetrics are challenging to recruit but critically important for training residents; having enough experience for comfort is hard to accomplish in the present 2-year residency model; learning how to deal with unpredictable emergencies in obstetrics

and neonatology is challenging; family doctors must have an effective on-call arrangement to sustain some balance in their lives; and family doctors seldom refer to other family doctors.

The few wonderful obstetric role models we have now are a precious resource. Its no use wasting their knowledge on residents who do not ever intend to practise obstetrics. We should put our resources into training the most promising future accoucheurs. Many studies demonstrate that residents who choose not to do obstetrics rarely change their minds.^{4,6}

A 2-year residency program with only 2 months of intensive obstetrics is just too short for most residents to gain enough experience and confidence to provide full-care obstetrics and be able to address unpredictable emergencies. Innovations, such as putting additional elective months together with the obstetric rotations and adding a rotation in neonatology help a little, but a more radical solution is needed to address the obstetrics training crisis.

While standard courses, such as the neonatal resuscitation program (NRP), might boost knowledge and confidence,⁷ our studies showed the NRP helped increase knowledge, but that knowledge slipped away over time.⁸ Boosting knowledge and skills through hands-on or video strategies was also not very effective.⁹

An Advanced Life Support in Obstetrics¹⁰ (ALSO) course is no substitute for time, volume, and exposure. Our study demonstrated that ALSO was not sufficient to build confidence in residents doing 2-month obstetric rotations. They still felt insufficiently prepared for emergencies.⁵

Balancing work and lifestyle is our challenge. Often, family physicians who provide obstetric services are their own worst enemies. Many feel obligated to attend *all* their own births. Although we have an on-call system, we seldom call on it, and the on-call system covers us only when we are out of town. This is not sustainable in the long run, and many residents shy away from obstetrics when they see how it can affect their lives.

Family physicians are reluctant to refer their patients to other family physicians for many reasons, such as fear of losing patients, concern they will be compared with the other family physician, and lack of confidence in other family physicians. We need to train our residents to refer and to do shared care and appeal to our colleagues to consider referring low-risk obstetric cases to us. It makes educational and economic sense.

Years as chair

In 1996, as chair of the Department of Family Medicine at McMaster University in Hamilton, Ont, I faced a new challenge: rapidly decreasing numbers of family doctors doing obstetrics in Hamilton. Last year, only 36 of 402 (9%) practised obstetrics; this year the number has declined to 29 (7%).

We came up with an ambitious new strategy to address this trend: support our faculty who provide obstetric services; sustain their lifestyles; provide a great learning environment for students and residents; provide high-volume obstetric experiences with family physician role models where family doctors would be happy to refer their patients; and provide independent funding from hospitals and the current fee-for-service system.

Our Maternity Centre of Hamilton was funded in June 2000 for a 2-year pilot project for \$1 million. We recruited a director (Dr David Price) to help develop the concept and a business plan. Each doctor gets a stipend for working in the centre doing prenatal and postnatal care. Births are fee-for-service. The doctors are on call 1 day in 10.

In order to ensure that the doctors in the maternity centre have a satisfactory after-hours life, a new joint after-hours weekend call arrangement that combines all three teaching units (approximately 25 000 patients) has been set up. The arrangement ensures some equity in clinical after-hours duties for all our family medicine faculty.

Recommendations

I recommend the following strategies to help promote greater interest among residents in practising obstetric care:

- Talk about the need to support family practice obstetrics and training with our colleagues, our communities, and our governments.
- Forget about training *all* family physicians to do obstetrics. We should develop a new program called the Family Practice Obstetrics Program. Let this program be unique like the College's Emergency Certification (CCFP[EM]) program, and let's put our energy into training only residents who choose to do obstetrics.
- Train family doctors who do not want to include obstetrics in their practices to do shared care and to refer their normal obstetric cases to other family doctors.
- Finally, train our residents in models that promote a balanced, sustainable lifestyle. ❀

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