

Duty to deliver

Producing more family medicine graduates who practise obstetrics

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Recently, my resident expressed concerns about including obstetrics in her future practice, about its unpredictable intrusion into private life and her sense of “having to put her life on hold.” Her family physician obstetrics preceptor reportedly responded, “Tough. I do it and have done it for years.” So my resident, like most graduating Canadian family medicine residents, will not practise intrapartum care. She will not experience alternate models of family practice maternity care that would ease her concerns because her residency program follows the College of Family Physicians of Canada’s (CFPC’s) accreditation guidelines on obstetric continuity of care. Based on this residency experience that only confirms her concerns, she is opting out. I could not help but think of the song by Queen: “and another one gone, and another one gone, another one bites the dust.”

There is a looming crisis in the provision of intrapartum care in this country. The CFPC alone cannot solve Canada’s increasing problem of insufficient accoucheurs (family physicians, obstetricians, and midwives), but it is time for the College to critically assess whether its own accreditation standards are contributing to the problem.

Intrapartum care by family physicians: the current situation

The proportion of Canadian family physicians who include full obstetrics in their practices diminished from 17.7% in 2001 to 12.9% in 2004.^{1,2} This is a trend in all provinces.³ Reasons for giving up obstetrics are many and complex, but negative effects on physicians’ personal lives are always among them.⁴⁻⁷ The decreasing numbers are not explained solely by older family physicians ceasing this practice. Physicians younger than 35 practising intrapartum care decreased from 26% in 2001 to 18.5% in 2004.^{1,2} New graduates are not including obstetrics in their practices. Godwin et al reported that while 52% of Ontario family medicine residents intended at the beginning of residency to include obstetrics in their practices, only 17% still did by the end of residency.⁸ Biringer and colleagues reported that only 16% of their Ontario cohort were practising obstetrics 2 years after residency.⁹ Believing obstetrics too disruptive of personal life was predictive of omitting intrapartum care from practice.⁸

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Social contract: CFPC’s stated commitments

The CFPC has a social contract to provide graduates from its training programs who will provide intrapartum care, a duty of care to women in this country made clear in both the College’s mission and the goals of the College’s Maternity and Newborn Care Committee. The mission reads: “The College of Family Physicians of Canada... strives to improve the health of Canadians by... supporting ready access to family physician services.”¹⁰ The Maternity and Newborn Care Committee includes the following among its goals: “to help retain physicians in the practice of intrapartum care” and “[t]o advise the CFPC on standards for the teaching of family medicine maternity care within the residency programs accredited by the CFPC.”¹¹ These statements show commitment to the present and future mothers of Canada and that our College intends family physicians to provide excellent maternity care.

Keeping this commitment demands more graduates who will provide intrapartum care. The College must ensure that residents do not lose their desire to include obstetrics in future practice. While there are causes beyond the College’s control (such as inadequate reimbursement, lack of specialist support, and fear of litigation), those factors within its control must be examined.

Effects of the current requirements for accreditation: an opinion

The CFPC’s *Standards for Accreditation of Residency Training Programs: Family Medicine; Emergency Medicine; Enhanced Skills; Palliative Medicine* (the Red Book)¹² outlines the standards used to accredit all Canadian family medicine residency programs. A program’s specific obligations in teaching obstetrics are described as follows:

[R]esidents in training programs *must* have the opportunity to follow some (preferably six or more) obstetrical patients to term and through labor and delivery throughout the course of the two-year program. In addition, residents *must* have an adequate specialty experience in obstetrics, which focuses on labor and delivery. It is important that this learning occur in a setting in which family physicians are also working.¹²

It is well established that the effect on personal life is a key deterrent to providing intrapartum care. The College’s current accreditation rules do not ensure

residents experience models of intrapartum care that address this specific issue. Rather, the CFPC mandates that they experience a model that emphasizes continuity of care, which greatly affects physicians' personal lives. In this model, residents have family physician preceptors who, for the most part, follow the traditional practice of being available for most births among their own prenatal patients. The College appears to focus solely on the model of continuity of prenatal and intrapartum care by insisting that residents follow this cadre of at least 6 women throughout pregnancy. Presumably the positive experience of this continuity will inspire residents to provide obstetric care. Evidence is to the contrary. Achieving this arbitrary 6 is unrelated to whether residents later include obstetrics in their practices.⁸ Even if residency programs are experimenting with other models, they are currently constrained by the accreditation standards to have continuity as the centre of any model of intrapartum care.

In this hallowed concept of continuity of care, we have imposed an unrealistic, unsustainable model that discourages future practice of maternity care. We are sacrificing the comprehensiveness of future practices. Young physicians vote with their feet.

New models must be developed and evaluated. To ensure this, the College must develop realistic, forward-looking accreditation standards. While ongoing research, such as the Babies Can't Wait project, might eventually be used to develop new models, the College should change its emphasis on continuity of care in obstetric training now. It should immediately encourage residency programs to offer various options for maternity care experiences so that residents' substantial lifestyle concerns are addressed. In so doing, we can hope to win back the residents currently lost during training.

New model

Other models of practice help sustain accoucheurs' longevity in obstetrics.^{7,13-15} David Price et al have described the success of the Maternity Centre in Hamilton, Ont.¹⁶ Shared prenatal care and specific shifts of intrapartum care are important to their model, enabling physicians to do this rewarding work while preserving their personal lives. Key to the success of this model is *predictability*. Family physicians attend births during rewarding, predictable, scheduled 12- to 24-hour shifts. This might entice graduating residents to include intrapartum care in practice—but first they must experience it during residency. Evaluation of the success of such options must follow.

The College's residency accreditation rules should be reworded to not only permit but mandate incorporation of different models of intrapartum care into all family medicine residency programs. Programs should be required to ensure that all residents have the option to experience a model of prenatal and intrapartum care with family physician preceptors emphasizing predictability and

shared responsibility, rather than just continuity of care. Residents would no longer be required to follow a magic 6 women throughout pregnancy. They could instead choose the option of being assigned to the obstetrics floor with their family medicine preceptors on scheduled days during their core family medicine rotations (ie, not just during their obstetrics rotation). During this shift, the resident and supervisor would attend all the births among patients registered with family physicians. Residents would experience a model of intellectually, technically, and emotionally satisfying medical work that can be easily incorporated into their personal and professional lives. The loss of continuity inherent in this proposed model might be balanced by the increase in provision of comprehensive care by many new family physicians. We must model sustainability of maternity care for our residents. The old model provided excellent patient-centred care, but to relatively few women. The proposed model offers excellent care for more women, by a greater number of family physicians.

Based on the experiences of the satisfied family physicians who employ this model,¹⁶ I predict that the rate of graduating family medicine residents who include intrapartum obstetrics would increase. It is worth a try. We know that the current mandate does not inspire residents to practise obstetrics. We must rekindle interest among those residents who have become lost to the future practice of maternity care because of their current residency experiences. Accreditation criteria must change now to permit—or perhaps even mandate—this change in the teaching of maternity care in family medicine residency programs across the country. ✨

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