

Rural maternity care

I can certainly relate to Dr de Leeuw's article in the July issue of *Canadian Family Physician*.¹

My family practice started in Flin Flon in northern Manitoba in 1972. We safely delivered many babies with GP obstetricians, anesthetists, and surgeons. We had a good rapport with our specialist colleagues in Winnipeg, Man.

I moved to Mission, BC, in the Fraser Valley in 1976 and continued to provide maternity care with my GP colleagues. We had access to specialty care in Abbotsford, BC, but we essentially ran a GP maternity unit. Then the regionalization mentioned in the article occurred. We lost our maternity unit, intensive care unit, and pediatric ward, and with this loss came the dilution and eventual loss of our GP anesthetists and surgeons. I also discontinued obstetric care. These were meaningful losses to our community and women had to go elsewhere to deliver.

However, in 2005, I started providing locums in the Northwest Territories, particularly in Fort Smith, Hay River, and Fort Simpson. Even at that time there was a tendency to electively transfer women to Yellowknife for delivery. The importance of community celebrations around birth mentioned in this article cannot be underestimated. Births in Yellowknife denied families this important cultural event. Fortunately, with the efforts of a group of dedicated midwives supported by traditional midwives, there is a robust midwifery program in Fort Smith and another developing in Hay River. Hopefully more programs will be initiated.

Is there a message for the training programs in support of rural obstetric care? It comes down to effective training and mentoring of students and residents. It means giving the opportunity for GP anesthetists, surgeons, and obstetricians to provide appropriate and safe care in rural settings. It means support for the referral centres and their connections to the rural communities. And perhaps most important, it means support of midwifery and nurse practitioner programs and integration of medical training with their programs. Our rural communities deserve better.

—Chris A. Finch MD CCFP
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Competing interests

None declared

Reference

1. De Leeuw S. The missing of mums and babes. Addressing Canada's rural maternity care crisis [Cover Story]. *Can Fam Physician* 2016;62:580-3 (Eng), e415-8 (Fr).

Concern is not based on evidence

The Canadian Task Force on Preventive Health Care strongly recommends against routine pelvic examination screening among asymptomatic women for noncervical cancer, pelvic inflammatory disease, or other gynecologic

conditions.¹ These recommendations are based on moderate-quality evidence that there is no benefit to women from pelvic screening examinations.² Indeed, the Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial involving 78000 women included pelvic screening for the first 5 years, and dropped the screening when no cancers were identified as a result of this intervention.³ However, there was evidence of harm in other studies, which reported that 1.5% of women received unnecessary surgery (open or laparoscopic) as a result of routine screening pelvic examinations,⁴ and more than one-third of women report fear, embarrassment, anxiety, pain, or discomfort associated with the pelvic examination.⁵⁻¹⁹

Dr Ladouceur laments the possibility that family physicians and residents who follow this recommendation will lose their pelvic examination skills.²⁰ He further speculates that this loss of skill will reduce compliance with cervical cancer screening in Canada, ultimately affecting women's health.

For any busy family physician in an academic or community setting, the need for appropriate pelvic examinations and opportunities for teaching are abundant. As the Canadian Task Force on Preventive Health Care report specifies,

pelvic examination is appropriate in other clinical situations, such as diagnosing gynecologic conditions when women present with symptoms or for follow-up of a previously diagnosed condition.¹

Concern that these recommendations would lead to declining skills and therefore poor uptake of cervical cancer screening is not based on evidence and seems tenuous at best. Studies on the topic have found that barriers to cervical cancer screening in Canada are related to ethnocultural, language, and socioeconomic factors among indigenous and immigrant women, as well as preference for female health care providers, rather than provider skill.²¹

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