

What will we lose if antepartum, intrapartum, and postpartum care becomes a focused practice?

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Almost 20 years ago, I followed a young woman through 3 pregnancies. She was a newcomer to Canada. Her health card showed her to be 18 years old, but much later she revealed to me that she was only 14 at that time. Since then, I have continued to care for her, her 3 daughters, and her older husband. I have counselled them on family planning and provided contraceptive care. The patient lost her brother to colon cancer at a very young age, and I have guided her through screening and grief. Her husband was recently diagnosed with prostate cancer. The bond that I have with this patient and her family is exemplary of comprehensive family medicine, and the maternity care that I provided for her was part and parcel of this ongoing relationship.

Growing shift to focused care

A recent article in the *Annals of Family Medicine* showed that more and more family physicians (FPs) are practising focused care rather than comprehensive family medicine.¹ This confirms what many of us in practice have observed for the past number of years. The study used secondary data in Ontario from 1993-1994 and 2021-2022 and compared the proportion of FPs in focused practice versus comprehensive care using billing data. In 1993-1994, only 7.7% of FPs were exclusively providing focused care. By 2021-2022, that proportion was 19.2%. The 3 most common areas of focused practice identified in the study were emergency medicine, hospitalist care, and addiction medicine, but I have also observed that maternity care is becoming more of a focused area for FPs.

I work as an academic FP practising comprehensive primary care in a teaching unit affiliated with the University of Ottawa in Ontario. The issue of focused practice has come to the forefront for me as I look to retire from the obstetric part of my practice. Since graduating from residency training 26 years ago, I have incorporated prenatal and intrapartum care into my comprehensive practice and have been able to do so as part of a family medicine-based obstetric call group. I also run a weekly prenatal clinic, which serves to care for pregnant patients from both inside and outside our large group practice, and to provide a learning experience for medical students and residents.

As I was planning to stop doing obstetrics (OB), and looking for a family doctor to replace me, it became clear that maternity care is becoming more of a focused practice rather than a part of comprehensive

primary care. For roughly the past 5 years, teaching units at the University of Ottawa have advertised for FPs with the skills and willingness to practise obstetric care as part of comprehensive practice. There has been very little interest in these positions. We are now hiring FPs who will provide prenatal, intrapartum, postpartum, and newborn care exclusively. I have felt uncomfortable with this shift, and this has made me reflect on the reasons for my discomfort. I can see that there may be advantages to a focused practice in maternity care, but I also worry that we may lose valuable things along the way, both for the practitioners and for our patients.

There is robust research describing the reasons why many family medicine graduates do not incorporate obstetric care into their comprehensive practice, and why family medicine obstetrics (FM-OB) providers stop doing OB once their practices or life circumstances are no longer compatible.²⁻⁵ This literature often cites the perceived underfunding of obstetric care as a reason for this trend, but increases in compensation have not resulted in more FPs either choosing or continuing to practise intrapartum care.^{2,4} Similarly, articles in this area have also advocated for more collaborative care with obstetricians and midwives. While there are some notable successful practices that provide this type of care in Canada, there are many systemic barriers interfering with widespread adoption of these models.^{6,7} Over the many years of my practice, however, I have observed other factors that I have not seen reported in the literature. For example, many family medicine residents learn in large academic hospitals where labouring patients are often seen as a ticking time bomb, a medical disaster waiting to happen. I believe this is the reason why so many family medicine residents report being more anxious about their OB rotation than most others, including internal medicine teaching units or emergency medicine.

Factors influencing focused practice

I have also observed that obstetric medicine has become increasingly interventional in the time that I have been practising, and working on the birthing unit seems more anxiety provoking now than it did in the past.⁸ Last, there seems to be a polarization of pregnant patients between those who seek medical management and interventions and others who prefer what is deemed a natural approach, with fewer tests and less intervention, possibly fuelled by the increased medicalization of labour

and birth. Managing patient expectations and counselling them about what is normal and what requires intervention is now more complicated and fraught, not to mention more time-consuming, especially in the context of the increased availability of imaging, genetic testing, and laboratory work.

I can see, therefore, why a focused practice in maternity care would seem appealing to those who enjoy this type of work and who could become experts in the field of low-risk OB. FM-OB providers can work comfortably in the middle ground between our specialized OB colleagues and the field of midwifery. With our well-developed skills in communication and our ability to critically appraise medical knowledge, we can often provide excellent care for pregnant people who are seeking compassionate and skillful care without unnecessary overmedicalization of a (most of the time) uncomplicated physiological phase of life. Moreover, a focused practice in maternity care also allows for more control over scheduling, can be quite lucrative, and allows for avoidance of many things seen as hassles in managing a comprehensive practice. I do not think that we can overestimate the stress that is associated with the juggle of OB call, regular family medicine, and home life, which often includes dependents, young and old, and possibly a spouse who is also juggling career demands and domestic responsibilities. At a time when fewer FPs choose to do any kind of maternity care, one can see that focused maternity care could be a way for family medicine to continue to engage in this type of care, perhaps filling care gaps, teaching a balanced approach to low-risk prenatal and intrapartum care, providing family-centred postpartum care that includes mother and baby, and maybe even becoming a resource for many rural communities who struggle with a lack of maternity care.

However, for family doctors to specialize in maternal and newborn care, rather than it being part of comprehensive family medicine, also feels to me like a considerable loss. Maternity and newborn care is different than other types of focused care in that it is situated along the continuum of health, rather than disease and illness, and one could argue that it is an essential part of comprehensive (or cradle-to-grave) care, not care that we should separate. Some of the most meaningful relationships with my patients were formed while following them through pregnancy and then continuing to care for them and their children afterward. For FPs who practise prenatal and postpartum shared care, even without intrapartum care, this can also hold true. If maternity and newborn care is hived off, to be provided by specialized FPs, we risk losing this part of comprehensive family medicine. And if more FM-OB providers become focused practitioners, there may be a self-fulfilling prophecy of fewer FPs feeling comfortable and competent to provide this supposedly specialized type of care.

Conclusion

As I struggle with this shift in family medicine, I can see both sides. On one hand, FPs who choose to focus their practice in maternity and newborn care could play an important role in sustaining, and maybe even increasing, the numbers and scope of FM-OB, striving to create renewed interest and providing valuable care. On the other hand, as primary maternity care becomes the purview of a focused few, comprehensive FPs may practise less and less of this meaningful and joyous care. One possible approach to explore would be to encourage more shared care between comprehensive FPs and focused FM-OB providers, and supporting this politically, practically, and financially so that patients continue to be cared for in a family medicine-centred way, and comprehensive FPs can continue to be involved in maternity and newborn care. I do not have all the answers, but I believe that this is an important issue that FPs need to consider and contemplate.

I have wondered if the daughters of my patient will remain in my practice as they start their own families. I have not yet had the privilege to follow patients whom I delivered into their own pregnancies, as some of my senior FM-OB colleagues have done. It is an aspirational goal and would truly reflect the continuity of comprehensive family-centred care that I love and support. 🌱

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Competing interests

None declared

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