Family Practice and Changing Patterns of Obstetric Care

John P. Geyman, MD

Major changes are taking place during the 1970s affecting overall patterns of obstetric care. As the birth rate declines, a new technology has developed in obstetric and neonatal care calling for more elaborate facilities and more highly trained personnel. These trends, together with economic and other related factors, are leading to reassessment of current practices with particular interest in consolidation and regionalization of obstetric care.

A major part of the "new technology" in obstetric care is fetal monitoring. Some enthusiasts of fetal monitoring recommend its routine use for all patients in labor, involving increased cost and a technical emphasis in obstetrics which tends to treat pregnancy as an *abnormal* process requiring intensive care in facilities which may be less accessible and more costly to the patient. Proponents of routine fetal monitoring would have us believe that the infant mortality rate will steadily decrease with its widespread use and that obstetric care is inadequate without its routine application. As yet, however, there is no controlled study documenting its value in decreasing infant mortality, and in fact we are starting to see reports of conflicting results. Two major studies, one in the United States and the other in Australia, show no difference in outcome or perinatal mortality in control and electronically monitored groups, and stress the importance of clinical observation and judgment.[1,2]

This is not to argue that fetal monitoring and related technical advances do not have an important place in today's obstetric care, but that we should document their value under specific circumstances before adopting them as routine in everyday practice. We should take a balanced approach to revising our methods of care for an essentially normal biologic process. In an excellent recent paper on perinatal care in California, Hawes and Hodgman draw the following conclusions:

> Every hospital in the state with maternity and newborn services must be equipped and have personnel trained to handle unexpected high risk patients, at least long enough for safe transfer to perinatal centers. This will require consolidation of services into larger units with enough deliveries to offset the cost of these added services. Remote rural community hospitals require special individual consideration. Perinatal centers offering complete high risk maternity and newborn services must be developed so that they are available within easy transport distance to all mothers delivering in the state. It is essential that every community hospital with a maternity service develop a liaison with a high risk center for consultation, for education of medical and nursing staff and as an ultimate source of care when the community hospital cannot cope with certain problems.[3]

These recommendations appear sound and generalizable elsewhere in the country.

Three papers in this issue of *The Journal* deal with different aspects of the role of family practice in obstetrical care. Candib presents an excellent overview of current trends in changing patterns of obstetric care in the United States and the rationale for the family physician's continued involvement in obstetrics.[4] Mehl, Bruce, and Renner report findings of a study of four family practices in the San Francisco Bay Area which show that practices including obstetrics comprise more minor surgery, gynecology, pediatrics, family counseling, and family care than those excluding obstetrics.[5] Ely, Ueland, and Gordon report an audit of obstetric care comparing family medicine and obstetrics-gynecology services at the University of Washington, which revealed no serious discrepancies between the two services in terms of quality of obstetric care.[6] Although the findings of these papers are in some cases preliminary and deal with only certain aspects of the interface between family practice and obstetrics, they point the way toward further studies in this important area.

Family practice has much to offer in modern obstetric care. It is both logical and necessary that the family physician continue to provide care for two individual patients – the mother and the newborn infant – as part of the family unit through a major event in the life cycle of the family. The increasing popularity of group practice will make it easier for the future family physician to maintain obstetrics as an integral part of family practice than it was for his predecessor in solo practice. Family practice residencies must continue to include substantial training in obstetrics-gynecology, and family physicians must become skilled in the use of modern obstetric techniques, the recognition of high-risk problems, and the appropriate use of consultation and referral. Audit of quality of obstetric care according to accepted criteria of "good care" must become commonplace. Perhaps the most important contribution of family practice to future obstetric care, however, is the effort to personalize and normalize obstetric delivery and newborn care as a significant human event in the life of the family. The challenge to family practice is to accept this responsibility and provide care of high quality as documented by process and outcome audits.

References

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