Obstetrics in Family Practice: A Personal and Political Perspective

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A heated debate is currently taking place concerning the style, methods and location of future obstetrical and neonatal care. On the one hand, there is a trend toward increasing technology of obstetrical and neonatal care with some professional groups favoring regionalization of these services to large regional centers. On the other hand, there are counterforces to such regionalization including community hospitals, many practicing obstetricians, nurse midwives, the women's liberation movement, the "alternative lifestyle movement," the Leboyer concept of delivery, the family-centered maternity care movement, and the family practice movement. This paper explores these issues and presents important reasons for family-oriented obstetric and neonatal care involving the family physician in community settings readily accessible to patients. The inclusion of obstetrical care as an integral part of family practice is important to the growth and development of the specialty.

Introduction

Work on this paper was started when I realized that my sense of the importance of obstetrics in family practice was not universally shared by other family practice residents or faculty. It is my contention that the success of family practice as an organization of medical knowledge and services will hinge on the involvement of family practitioners in the obstetrical care of the families whom they serve. At least in the eastern United States, family practice as an organization of care is struggling to achieve an acceptance and a legitimacy both with patients and with other specialities. To survive and grow, family practice must define itself as a clear-cut discipline, separate from other voices clamoring to represent primary care. The forces of specialization, technology, and regionalization of services may try to confine the development of family practice. However, family practice may be able to join with the growing consumer movement in demanding family-centered maternity care. Such a union could conceivably strengthen family practice and consumer control of medical care in general.

As a family practice resident, I am frequently asked, "What is the difference between family practice and primary care?" My initial answer has usually been that family practice provides comprehensive care for the whole family and sees each person as a member of the family unit. Also, I do not see my work as a mixture of internal medicine, pediatrics, and gynecology. I see it as caring for whole persons whose problems are not subdivided into the fields of knowledge that medicine has spawned to divide up information. (For example, mother and child come in for a problem the child is having; the mother is concerned about the problem. To me this situation is not the "pediatrics" in my work; it is a family problem.)

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More recently I have been aware that my approach to pregnancy and childbirth also distinguishes family practice from primary care. Pregnancy, both planned and unplanned, is obviously a crucial time in the growth of the family. To help patients deal with the experience of pregnancy, I have been bringing together two or three pregnant women in my office for prenatal visits so that they can talk about what is happening to their feelings and their bodies – to open up discussion to questions patients have trouble asking when they are alone. Later on in pregnancy I have been trying to schedule visits so that the fathers could come also – to talk about changes that the new baby will make for them, to go over the birth process, to open discussion about circumcision. Depending upon the hospital setting of the delivery itself, this preparation usually results in a family-centered experience when the new baby enters the world.

Unfortunately, the hospital settings available to me as a family practice resident are not oriented toward making family-centered or even mother-centered care important in the atmosphere surrounding and practice itself of the birth process. Typically, the mother and father are separated after arrival at the hospital. The woman is stripped of her clothes, shaved, and perhaps given an enema. (The necessity of the latter two uncomfortable procedures is disputed). More often than not, the mother is medicated in active labor; then she is regarded as helpless and unable to make decisions.

A large percentage of women receive either conduction anesthesia (caudals and epidurals) or general anesthesia; both lessen or make impossible a woman's active participation in the birth process. The father is usually considered a bystander who might get in the way, rather than an active participant in supporting the mother through the labor and delivery process. Rarely is he allowed to touch or hold the baby after the delivery. Despite research concerning the importance of early maternal-infant contact,[1] a mother may be separated from a normal infant for 12 or more hours, depending on hospital policy. Mother, father, and baby may not be reunited during the hospitalization. Sibling visitation is permissible only at a few progressive hospitals. The mother may not be encouraged to breast feed or to have rooming-in, both of which would promote strong maternal-infant bonding. Clearly, I am merely scratching the surface of common obstetrical policies. Nevertheless, it is evident that the system does not function at the hospital level to put information and control back into the hands of the mother and father, but rather to strip them of their role in the delivery process.

These hospital policies are not surprising to childbirth educators who have been working for years to try to change obstetricians and hospitals to promote prepared childbirth and family-centered care. What is new, I believe, is the growing group of *family practice* physicians who see the kind of birth process that they want to take part in as increasingly difficult in specialty-oriented hospitals. This is the first time, I think, that a significant group of professionals with a firm philosophical commitment to family care have allied themselves with a growing consumer movement to promote change in the entrenched medical and hospital environment.

It is true, however, that there are family physicians and family practice residents who are not interested in the practice of obstetrics. Sometimes this choice is based on the erratic hours, or on the semi-surgical nature of the risks in obstetrical care. Sometimes they feel a personal discomfort with the labor and delivery process as they have seen it practiced in various settings. One family practitioner put it, "I don't like screaming women." When I pursued this line of thinking with him, it emerged that the practice setting where he tried to do obstetrics was a small hospital where there was one doctor and one circulating nurse to handle everything that might occur. He found this frightening and began to refer his pregnant patients to general practitioners who did deliveries in that same hospital. He felt inadequate to practice obstetrics in such a setting.

Obstetrics as Essential to Family Practice

There are a number of fundamental contradictions in separating out obstetrical care from family practice. One problem with family physicians not doing obstetrics is that the medical specialty system functions to steer patients away from us. Both a woman seeking prenatal care and a woman seeking care for a newborn child are two clearly recognizable points of entry to the medical care system. The decision about which doctor or clinic a woman should go to for her own care or for her child's well-baby care is usually a decision made by her with important input from her own mother, her friends, and her neighbors. If a woman goes to a family physician, she is reassured that the person she is getting to know as the doctor will be the same person she comes to for her child. But what happens if she happens to go to an obstetrician for prenatal care? or to a prenatal clinic at the hospital? Towards the end of her pregnancy the obstetrician may ask her to which pediatrician she will be taking the child. If not in the office, then in the hospital the nurses will ask her which pediatrician will care for the baby, because the obstetrical nurses are responsible for filling out the baby's hospital forms, including who will be the baby's doctor. Frequently, in the minutes after delivery while the mother is still lying on the delivery table, I have heard the nurses ask, "Which pediatrician for your baby?" or, if the patient is very young or low-income, "Which baby doctor?" Clearly, the specialty obstetrical system and the nursing and hospital routines which are part of it, direct children of new mothers into the specialty system unless at that moment of contact the family practitioner is present, or the mother has been carefully coached to respond with the name of the family physician.

Another way that obstetrics is central to family practice is in the composition of a practice. It is common knowledge that a family doctor's practice "ages" with him or her. Central to this concept is the fact that many currently practicing family physicians who were doing what was called "general practice" in the 1950s, stopped the practice of obstetrics within the last ten years. Their pregnant patients went to obstetricians, and the new babies were funnelled to pediatricians. The family physician is left with a practice of maturing families with the children now en-

tering adolescence. In general, these family physicians state that the enormous time demands of doing obstetrics with its inevitable night call were the major reason that they dropped obstetrics. Some specifically cite the needs of their own maturing families and the necessity of being home at night. Often they were solo practitioners with no adequate system of night coverage for either patients at home or in the hospital. Now group practice and the concept of shared responsibility are widely accepted both among physicians and patients. Family practice residents are trained to take responsibility for group coverage. With group coverage systems, new family physicians can expect to offer obstetrical care to their families for as many years as they feel comfortable doing so.

In the meantime, however, patients have been educated to expect obstetrical care from obstetricians, and new baby care from pediatricians. Both of these disciplines have had to adapt to the growing influx of patients: pediatricians have welcomed nurse practitioners to handle much of the load of well-baby checkups and patient education: obstetricians have begun raising the ironic (to me) question of whether they should be "primary care physicians for women." Bringing obstetrics back into family practice is crucial to reversing this trend towards fragmentation of family care which became the leading dynamic of access to care of the 1960s. During that time, many family physicians stopped doing obstetrics as a means of limiting the growth of their practices. However, now that family practice itself is in a period of accelerating growth, obstetrics is the discipline we should be involved in to continue to grow. Stated in another way, *family practitioners doing obstetrics is an essential way of guaranteeing the growth and development of our own specialty as well as assuring the ongoing education of our patients to demand comprehensive care and continuity of care.*

Another fundamental way that obstetrics is crucial to family practice is in the very nature of care that a pregnant woman and her family require. Obstetrical care is the best example of a family's needs for longitudinal care during *health*, with an emphasis on nutrition; patient preparation and education; and changing family dynamics. No other single event in the family life cycle is as open to physician support and guidance over an extended period of time. Clearly, block rotations in obstetrics under the supervision of specialized obstetricians can in no way provide family practice residents with this kind of experience in continuity of care. The longitudinal experience of knowing patients before they are pregnant, being the provider of the news that they are pregnant, dealing with the patient's fears and hopes about that process, following the changes in the patient's state at different stages of pregnancy, observing changing family dynamics with the expectation of the new baby, being present during the labor process, mediating that process to both mother and father and extended family, participating with the family in the delivery, assuring the family of normalcy or explaining the event of any abnormality in either mother or baby or the process itself, and, of course, following mother, baby, and family back into the home setting – *this by nature longitudinal process is at the center of the experience of family practice.* This process is obscured by training in block rotations in the hospital setting under the supervision of specialists.

If we agree that obstetrics is central to family practice, we must examine our service and educational goals in that area, and the sources of both opposition and support for those goals from other directions. First, what are the goals of the family practice movement in relation to the delivery of obstetrical care? I see three major objectives:

1. To develop an alternative strategy to the delivery of maternity care which provides a family-centered experience for all members of the family.
2. To provide access to training for normal childbirth to family practitioners at different levels of training.
3. To assure the growth and development of family practice as a discipline by offering care to families entering the health-care system at the moment of pregnancy.

It is important to understand the powerful opposition to these three objectives as well as the potentially powerful movement which could support them.

Increasing Technology in Obstetric and Neonatal Care

One major contrary development is the increasingly technological approach to obstetrical services and neonatal care in the last ten years. Fetal monitoring, a major technological advance, has evolved from a dubious procedure used only in the university setting for high-risk mothers to the *sine qua non* of "normal deliveries" in many obstetrical units. Fetal monitoring initially started as a research technique for learning more about the fetus in the labor period. The work began with high-risk patients in danger of fetal morbidity and mortality. The justification has centered around improving the infant mortality figures in this country (the United States ranks approximately 15th among the developed nations). This notion of *late intervention* in problem pregnancies is typical of the "anti-prevention" ideology which is characteristic of our medical research. It is analogous to balloon pumping after myocardial infarctions.

One consumer newsletter has described this ideology aptly:

> This position, expressed in the attitude that 'there is no such thing as a normal labor and delivery' tends to regard active and technological management of the birth process as desirable for both high risk and low risk mothers.

The alternative:

> . . .advocated by vocal consumers of health care, and some health professionals, . . .to attack the problem at the level of primary prevention – nutrition counseling, food supplement programs, health education – coupled with continuity of care (a characteristic pattern of care in countries with lower infant mortality rates): In other words to lower the number of high risk cases rather than expand capacities to handle a stable population of high risk cases.[2]

Tremendous amounts of research money and expertise are poured into care at a highly technological moment. The increasing technology has an independent dynamic of its own. In addition, there is an economic basis to increasing technological intervention. The corporations who sell the fetal monitors also sponsor the research on

the use of the monitors. Researchers advocate the use of internal "invasive" monitoring (with an intrauterine catheter) over external monitoring because the data collection is more accurate and reproducible. Monitor manufacturers even provide the educational conferences on the use of the machines. Naturally, the fundamental question of whether to monitor or not is not asked in this setting.

Advocates of fetal monitoring claim credit for improving infant mortality statistics from 1969 to 1975.[3] They state that infant mortality for monitored high-risk infants is lower than for unmonitored low-risk infants.[4] They conclude that all mothers should be monitored. At the same time, however, the relative ranking of the United States in comparison to other countries has fallen: in 1950 we were 6th; in 1960 we ranked 10th; and in 1969 we fell to 15th.[5] Perhaps American obstetrical practice actually puts even a low-risk mother at risk. For example, routine use of medication, outlet forceps, conduction anesthesia, and the dorsal lithotomy position may create a relative condition of risk.

What are the effects of monitoring itself? If a woman is lying on her back with a catheter inside her uterus to measure contractions, an electrode on her baby's scalp to record its heartbeat, and an IV in her arm to stimulate contractions, and if she has a catheter in her epidural space to relieve her of the pain of these contractions, who is asking what effect this has on the mother and the baby? I am not trying to be sensationalistic about this situation. The use of routine fetal monitoring and routine conduction anesthesia is currently advocated in obstetrical circles as the "best" care available. This discussion of increasing technology in obstetrics has not dwelt on the positive scientific advances made in high-risk perinatal care through fetal monitoring. Rather, I have *chosen* to emphasize for this discussion how technological, high-intervention obstetrical practice removes childbirth further from the realm of normal biological process.

The post partum period is another critical time in family life which has been affected by technology. At a regional center for neonatal care, a newborn might be transferred from the obstetrician's hands to a radiant-heat warmer. The infant would be rapidly dried by the nurses, wrapped up, shown to the mother, and transferred to the nursery. Current practice is to monitor continuously the respiratory status of every newborn for the first eight to twelve hours of life. Contrast this chain of events with a sequence where the baby is passed to the mother, nursing is begun immediately, and father, mother, and infant remain together for a period of time. The work of Kennell, Klaus, and Fanaroff has shown that prolonged maternal-infant contact in the first few hours of life increases maternal attentiveness. Attentiveness has been correlated with infant inquisitiveness.[6] The five-year follow-up of Kennell and co-workers' mother-infant pairs reveals greater IQ scores and increased verbal comprehension in the children who had prolonged contact as infants (Lecture by Fanaroff at the Bay State Medical Center, May 12, 1976). Here we can see a contradiction between the "best" technological care and the "best" psychological care for normal mothers and infants. At the extreme, neonatal intensive care units are saving premature and severely ill newborns; however, the loss of maternal contact seems to make these infants vulnerable to child abuse.[7] Hence, increasing technological care in obstetrics and neonatology may have long-range effects on families that we are just starting to recognize.

Regionalization of Obstetric and Neonatal Care

Hand in hand with the increasingly technological services comes the accelerating trend towards regionalization of obstetrical and neonatal care. The Committee on Perinatal Health, funded by the March of Dimes, has prepared guidelines for the regionalization of obstetrical and neonatal care. Interestingly enough, the American Academy of Family Physicians has endorsed these guidelines along with the American Medical Association, American College of Obstetrics and Gynecology, and the American Academy of Pediatrics.[8] The Committee proposed a regional system connecting three levels of hospitals by communications, transport, and education. Level I hospitals would manage uncomplicated obstetrical and neonatal patients and would transfer any problem patients to a level II hospital. Despite the statement that "family centered care [is] best provided . . . in the level I unit,"[9] the guidelines recommend the consolidation of several level I units into a single level II hospital. Most deliveries would occur in level II hospitals, offering maternal and infant services for uncomplicated and most complicated patients. Level III units would have all the facilities of level II hospitals plus a neonatal intensive care unit. Level III units, designated as regional centers, would have responsibility for the transport system, data analysis, and continuing education in the region.

Promoters of regionalization state that infant mortality is reduced in hospitals with at least 2,000 deliveries per year.[10] However, infant mortality rates are not the only statistics used to justify regionalization. Small obstetrical units have lower occupancy rates than larger units, which means higher costs for hospitals and insurance companies. Thus, Blue Cross becomes one of the proponents of regionalization. When Blue Cross of Massachusetts and the Massachusetts Department of Public Health conducted a "Statewide Maternity Study" in 1972, they found that 49 percent of the births occurred in hospitals with under 1,500 deliveries per year.[11] According to minutes in April 1975, the Office of Comprehensive Health Planning in Massachusetts adopted standards and guidelines requiring that maternity units have an occupancy rate of 75 percent and a minimum annual rate of 1,500 births. Here we can see the interest of the insurance companies link up with the goals of regionalization to channel half the state's births into larger hospitals despite the obvious public reliance on community hospitals.

Already some small hospitals have been squeezed out by regionalization standards for triple nurseries which were too expensive for them to maintain. At the other end of the spectrum, level III hospitals will need to average 5,000 deliveries per year to *cover costs.*[12] While "bigger" may be "better" statistically and fiscally, the quality of care does not necessarily improve at regionalized hospitals.

How will regionalization affect care?

First, technology dictates centralization and vice versa; only a regional center will be able to provide each mother and baby with a "fetal intensive care unit." If this is the requirement, then regionalization becomes defined in terms of it.

Second, regionalization brings control of obstetrical patients into the university medical center setting, out of the hands of the community hospitals and private practitioners who practice there. This trend is sponsored by both government-supported and corporation-supported research, and is backed by government guidelines on obstetrical care at the state level.

Third, the declining birth rate limits the number of deliveries available for training medical students and obstetrical residents (much less family practice residents). Centralizing all the deliveries in university settings ensures that whatever deliveries occur will be available for teaching purposes.

Fourth, regionalization brings obstetrical care entirely under specialty control; family practitioners will not be delivering babies in the level III tertiary care regional center.

Fifth, regionalization of deliveries at hospitals relatively distant from where patients live, in large, highly specialized institutions, which are primarily oriented towards high-risk, high-intervention pregnancies is not likely to promote family-centered care with an emphasis on the experience for the family. Already, high-risk infants are separated from mothers for prolonged periods at great geographical distance from their homes. (Regionalization plans make no provision for the mother to be transported to the same hospital as the infant.) Central concepts of family-centered maternity care – father as labor coach, fathers in the delivery room, early and prolonged maternal contact, breast feeding immediately post partum, sibling visitation – stand in sharp contradistinction to current philosophy and practice of the regional center for perinatal care.

Counterforces to Regionalization of Obstetric and Neonatal Care

Let us examine the various, although so far ununified, forces working in opposition to increasing technology and regionalization of obstetric and neonatal care.

1. *Community hospitals.* Obstetrical services of a large enough volume can be a source of income to the community hospital and provide the basis for future family use of the medical facility. In cities where regionalization is occurring, community hospitals have competed actively to keep their obstetrical services open. Since one of the criteria for maintaining obstetrical services is the number of deliveries per year, remaining hospitals are now more interested than previously in consumers' desires regarding maternity services.

2. *Private practitioners of obstetrics.* With delivery rates dropping, private physicians who are not immediately affiliated with a university medical center may find that the facilities they primarily use for their patients are being regionalized out from under them. The threat of losing patients and therefore income has put these physicians into a stance more open to listening to consumer input and demands regarding maternity services.

3. *Nurse-midwifery.* Traditional nursing is undergoing tremendous change and upheaval including the trend towards specialization and increasing responsibility both in outpatient and hospital settings. Included in this trend are many nurses who see nursing and nurse-midwifery as a more appropriate way of providing prenatal and obstetrical care. Philosophically, nurse-midwifery approaches childbirth as a natural process requiring minimum intervention for the majority of patients. Though nurse-midwifery is currently enjoying a resurgence, it is still based upon hospital care under the supervision of an obstetrician, as any other approach would jeopardize its still tenuous status. While not necessarily opposed to regionalization, nurse-midwives are among some of the more vocal supporters of family-centered maternity care.

4. *The women's liberation movement.* With increasing understanding of their medical needs, women are demanding the right to determine the nature and quality of their medical and obstetrical experiences. Women's community health services maintain referral lists of physicians and hospitals which are open to allowing women more participation in determining the events in their health care.

5. *"Alternative life-style movement."* For lack of better words, I use this term to describe the growing group of people who find that the values and style of their personal lives are significantly out of keeping with medical care as it is currently offered in this country. They express a preference for paramedical, paraprofessional, anti-technological care, with an emphasis on diet, natural remedies, and minimal medical intervention in natural processes. These people are not all "hippies." In a study of home births in San Francisco, Lester Hazell has shown that many are middle class families whose values are characterized by close-knit family life.[13] While medical professionals may be very uncomfortable with these values, this group of people is growing, and their interest in childbirth is strong. Many are completely opposed to hospitalization for childbirth. In Boston, there are currently at least three organizations sponsoring home delivery, some affiliated with physicians who are willing to assist in the process. While one spokesman for regionalization stated that home delivery should be considered an act of "criminal negligence,"[14] the majority of the obstetrical community has not yet even become conscious of the significance of the demand for home birth.

6. *The Leboyer method of delivery.* Interest in this new technique of obstetrical delivery is literally sweeping the country. Leboyer is a French obstetrician who popularized his method through his film and book, *Birth without Violence,*[15] and through a United States lecture tour in 1975. He advocates peaceful birth of the infant in semi-darkness with subsequent immersion in warm water to ease the infant's transition from the womb to the world. Parents have read about the quiet births in local papers and are barraging obstetricians with requests for the new method.

Feelings in the medical community run hot and cold about Leboyer. Some neonatologists are preoccupied about infant heat loss with immersion and then drying. They also maintain that it would be impossible to evaluate the infant's color in a dimly lit delivery room. Some obstetricians, on the other hand, are enthusiastic about the method and have modified their

delivery room practice accordingly. In my community, where three hospitals are competing for deliveries, the regional perinatal center has taken a public stand against Leboyer deliveries. The community hospital with the lowest annual birth rate is welcoming parents interested in the method. The local childbirth education group points out that the perinatal center does not permit patients any choice. Controversy among professionals about the Leboyer method was highlighted in a recent Sunday feature section of the local paper, stimulating further consumer interest. This sequence of events probably typifies many other American communities.

Some professionals reject the method as a fad. Others consider hospitals and physicians advocating the method as opportunists who are jumping on the bandwagon to increase their delivery statistics. What strikes me as important about the Leboyer method is not the specific delivery room practice but rather the incredible popularity the method has achieved in a year's time. I believe this mass public sentiment to influence the birth events reflects consumers' awareness of their disenfranchisement from the birth process. Their desire to determine *the quality of the birth experience* represents another example of people trying to take control over their medical care.

7. *The family-centered maternity care movement.* The roots of this movement lie in the development of relaxation and breathing techniques to relieve the discomfort in childbirth. Involvement and participation of the father as labor coach is a natural development, as is the return to immediate breast feeding. There are now several national associations organized into local branches, which sponsor training and education for parents. Among them are the International Childbirth Education Association, the Maternity Center Association, and the American Society for Psychoprophylaxis in Obstetrics. These groups are growing politically aware of their potential power as consumers of medical care. Many are active in pressuring local physicians and hospitals to provide family-centered care; other groups are working actively to make family-centered care one of the criteria for evaluating which hospitals shall continue to provide services. Yet other groups, like the Maternity Center Association, are sponsoring domiciliary settings where a family may go for the few hours around childbirth, but then return home the same day with the family intact. The importance of this strong and growing consumer movement on even a very entrenched and technological hierarchy in obstetrics cannot be underestimated at this point. As long as consumers can control where they have their maternity experiences, they can exert a significant impact on those services. It is devastating to learn that regionalization officials, having already anticipated problems with consumer acceptance, have proposed making third party payments for obstetrical care for high-risk mothers *conditional* upon their using the level III regional center.[16]

8. *The family practice movement.* At the outset I stated why I thought providing obstetrical care was crucial to the growth and development of family practice as a discipline. In order for family physicians to do this, they must have access to training in obstetrical and neonatal care. But they will not be learning family-centered care at the elbows of obstetricians in regionalized centers. To learn about normal pregnancy and its impact on the family, and about normal childbirth and the time thereafter, family practice residents will need to see family-centered care in action. They need to see family practitioners delivering babies; they need to work with midwives providing care; they need to become involved in the care of their own families on an ongoing, longitudinal basis. I believe that this will only occur in settings where there are family practitioners active in obstetrics and where there has been a strong consumer movement to change medical, nursing, and hospital policy towards promoting family-centered care. It is my hunch that the strongest allies of family practitioners in this goal will be the community hospitals who wish to continue doing obstetrics, the small number of enlightened private obstetricians who do not view family practitioners as a threat but rather as potential referral sources and as colleagues in providing family-centered obstetrical care, and, of course, the growing consumer movement for family-centered care.

Conclusions

Family practice programs need to initiate contacts with consumer groups active in family-centered care to begin exploring mutual concerns and goals in obstetrical care in their community. In addition, family practice programs must become involved with local health planning councils responsible for guiding regionalization in their locale. An early goal is to ally ourselves with the consumers of health care and to engage in a process of mutual education. Thus, we can assure our long-term involvement in family and obstetrical care. In so doing, we will encourage consumer understanding of family practice as the logical outgrowth of family-centered maternity care.

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