Family Practice Maternity Care In America: Ruminations On Reproducing An Endangered Species — Family Physicians Who Deliver Babies

Walter L. Larimore, MD, and James L. Reynolds, MD

Background: **The majority of family physicians do not deliver babies. One reason might be the family physician's intrinsic comfort with person- or patient-centered care compared with the common obstetric approach of disease or physician-centered maternity care. Another reason might be the uncritical intrusion of technology into maternity care. In addition, family physicians often are made to feel unwelcome in many maternity care systems.**

Methods: **The medical literature from 1984 to 1994 was searched for the topics of obstetrics, maternity care, family-centered birthing, and family practice education. Reasons to argue whether family physicians should provide maternity care were selected, and articles were chosen that described the self-reported reasons students, residents, or physicians give whether to provide maternity care.**

Results and Conclusions: **There is no scientifically supportable reason for excluding family physicians from maternity care in any setting, and the current maternity care system, in many locations, creates an attitude of taught helplessness among family physicians. In addition, family practice educators must for a variety of reasons be the primary role models and teachers of family-centered birthing for family practice learners.**

Generally, the groups that should be involved in providing maternity care in the future should include (1) better informed and more independent pregnant patients, (2) maternity care nurses, (3) doulas, (4) midwives, (5) family physicians, and (6) specialized physicians. Specifically, family physicians and midwives have a historic and philosophic similarity that would argue for a much closer working and practicing relationship between these two professionals.

Family-centered birthing provides excellent outcomes. Birthing is both foundational and intrinsic to family practice. Conversely, without family physicians maternity care in America might not be able to reach its full potential. (J Am Board Fam Pract 1994; 7:478-88.)

When one asks the question "What is the future of obstetrics or maternity care in family practice?"[1-20] it is often restated by many outside and some inside the family practice community as, "Should family physicians be practicing obstetrics at all?"[1,3,6,16,17,19] The majority of family physicians do not provide maternity care, and for the last 25 years there has been a strong movement away from maternity care in family practice.[3,6,9,10,12,13,16,17,21-25] This movement has been described as an "exodus";[3] therefore, it seems appropriate to quote from *Exodus*:

> The King of Egypt said to the Hebrew midwives, "When you help the Hebrew women in childbirth and observe them on the delivery stool, if it is a boy, kill him; but if it is a girl, let her live." The midwives, however, feared God and did not do what the King of Egypt had told them to do; they let the boys live. Then the King of Egypt summoned the midwives and asked them, "Why have you done this? Why have you let the boys live?" The midwives answered Pharaoh, "Hebrew women are not like Egyptian women; they are vigorous and give birth before the midwives arrive."
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> So God was kind to the midwives and the people increased and became even more numerous. And because the midwives feared God, he gave them families of their own.[26]

This ancient passage illustrates at least two principles: First, that healthy (vigorous) women could safely birth their own babies without intervention most of the time, if allowed to do so. This principle is still true today.[27,28] Second, the passage reveals that the delivery of babies was a political issue. It, unfortunately, remains so.[1,3,9,11,29-34]

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From a private family practice in Kissimmee, Florida (WLL), and the Department of Family Medicine, University of Western Ontario, London, Ontario (JLR). Address reprint requests to James L. Reynolds, MD, 346 Platt's Lane, London, Ontario, N6G 1J1, Canada, 50018.

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Some suggest that maternity care always will be an issue of power and control.[3,9,13,21,30-32,35]

If these ancient truths persist into our time, then what can we as family physicians learn from this and other lessons of history? How can we apply these lessons in our modern context to examine critically the question "Who should be providing maternity care to women?" A review of our historic roots might assist family physicians to gain both a foundation and a platform for glimpsing into and, we hope, shaping the future of maternity care, or at least maternity care provided by family physicians.

Methods

We searched the medical literature from 1984 to 1994 for the topics of obstetrics, maternity care, family-centered birthing, and family practice education, using our own extensive article files. We sought reasons why family physicians should or should not provide obstetric care, as well as self-reported reasons why students, residents, or physicians chose to provide or not provide obstetric care.

The Past — Person (Patient)-centered Maternity Care

The word *obstetric* originally meant to stand by or to stand with. Until just the last 100 years this care was usually given by women to women.[28,29,32,34] The word *midwife* means the woman with or the woman beside. Historically these birth attendants used as their therapeutic instruments compassion, caring, experience, patience, listening, and tradition.[29,32,33] During the last century, however, physicians changed this approach.[3,11,28,29,32] As an increasing number of trained physicians became available, it was the physician rather than the midwife who was called to assist the laboring woman.[3,32,33] Thus, the independently practicing woman birth attendant, the midwife, nearly disappeared in North America and in Great Britain.[3,32] Those midwives who remained became primarily hospital based and controlled by physicians, who were for the most part nearly all men.[3,29,32]

Recent History — Disease (Physician)-centered Maternity Care

Early in this century labor and delivery, which had always been considered a vital, normal, and natural life event, became defined as a disease or even a surgical process. A strategy of physician control was needed to manage labor and delivery in such a way as to make the best of expected worst possible outcomes, no matter how improbable these outcomes might be.[3,9-11,15,27,28,32,34-40]

As a result, maternity care evolved from a female birth-attendant, home-based, family- and community-supported tradition to a predominantly hospital-based, male-dominated religion. We use the term *religion* to mean a practice based primarily on faith. A large part of modern obstetric technique, belief, and technology has been developed and practiced uncritically on childbearing women based on a blind faith that this system would improve outcomes by reducing maternal and neonatal morbidity and mortality.[37,38,40-44] Did it? Probably not, for critical review reveals that despite wide differences in the application of obstetric interventions, all western countries have experienced a decline in perinatal mortality.[3,35,44-48] It is now contended that these reductions in maternal and neonatal mortality resulted not from medical intervention alone, but also from improvements in the health of childbearing women, improvements in the sanitary and community health of their communities, and declining birth rates.[3,43-45]

Reaction of Family Physicians to Obstetric "Technologization"[40]

Family practice as a specialty was born in the late 1960s, in the middle of an exponential growth of technology in obstetrics and neonatology. The philosophy and practice of this technology created a difficult environment for most family physicians in which to learn and practice, so that for the last 25 years family physicians have decreased their involvement in obstetrics.[48-55] The primary reasons for this decline have been reported to include malpractice insurance issues (cost and lawsuit risk) and lifestyle issues (personal and professional schedule disruptions). There is growing evidence in the medical literature, however, that these self-reported reasons to abandon or never practice maternity care in family practice might have represented only professionally acceptable excuses to escape from a type of obstetrics that was both very uncomfortable to practice and for reasons that were even more difficult to discuss.[11,13,14,48-59] Evidence for this concept is supported by studies of family physicians who drop

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maternity care because of the cost of malpractice insurance. For these physicians even a substantial reduction in the cost did not stimulate a return to or increase in maternity care in rural family practices.[58,60] It has been suggested, therefore, that family physicians might have more influential reasons to avoid providing maternity care services, even though these reasons might be more difficult to admit or discuss.[1-4,9-16,19,54,58-60]

Many of our family practice residents (70 to 80 percent) enter family practice open to, hoping to, or planning to deliver babies, yet by the end of their residencies, anywhere from 50 to 96 percent have chosen not to provide maternity care.[14,20,27,52-55,61,62] Why do they make this choice? What dilutes and diminishes their initial enthusiasm? Traditionally our specialty has looked outwardly for the reasons. We suggest, along with others, that we look within.[6,9,11-14,18] We have observed several factors that could serve to demotivate many of our best and brightest from enjoying the many satisfactions of childbirth care:

1. Very often obstetrician-gynecologists, obstetric nurses, and even some of our family practice faculty imply, directly or indirectly, that family physicians have neither the capability nor the proper training to look after pregnant women, especially women in labor.[3,13,30,63]
2. The routine and uncritical use of technology and intervention in low-risk labor is usually taught by and extensively practiced by obstetricians, who as limited-care specialists often believe that family physicians are not capable of technical or interventional obstetrics.[3,9,27,28,30,34-40] These beliefs can result in an attitude of "taught helplessness"[3] among family physicians toward pregnant patients. In addition, should family physicians choose to practice as "mini-obstetricians"[9] in their family practices, they might find themselves dissatisfied with a practice style and philosophy that is disease and not patient centered. Alternatively, they might feel the need to receive additional training or obstetric fellowships in interventional obstetrics to avoid feelings of helplessness or discomfort.
3. The elastic and overused term *high-risk* has been manipulated to minimize the chance of missing even a single high-risk patient (despite overidentifying the majority) and therefore can easily be applied to almost every pregnant woman.[1,3] As a result, family physicians are frequently told that low-risk can be defined only retrospectively, that is, 6 weeks to 6 months postpartum, effectively extinguishing the idea of normal birth.[3,63]
4. Mandatory consultations can be used to infantilize family physicians still further.[3,13,19,20] A privilege to take care of a problem with mandatory supervision is an unfair and unwarranted credentialing control that for the specialty of family practice can result in both procedural impotency and reproductive sterility.[13,19]
5. Increasingly family physicians are reporting that their obstetric colleagues are refusing to provide backup, consultations, or referrals, therefore causing family physicians either never to start or to stop maternity care services.[3,31]
6. Finally, family practice as a specialty has allowed its future, its residents and medical students, to be taught normal, routine maternity care by a limited-care specialty that, for the most part, neither understands family practice nor seems to want family physicians to practice maternity care.[13,30] Academic family medicine has often allowed a near monopoly of inappropriate training for normal labor and delivery care for family physicians. Could these obstetrician-gynecologists, themselves facing a relative oversupply (at least in suburban and noninner city urban areas)[3] perceive the family physician as a potential future business competitor?

If these theories contain any truth, as we suspect they do, then it is surprising that so many family physicians continue to provide maternity care and encouraging that the decline in the number of family physicians delivering babies might have passed its nadir.[61,62,64]

Why Some Say Family Physicians Should Not Do (Physician- or Disease-centered) Obstetrics

Let us review some of the arguments proposed for the belief that family physicians should not provide obstetric care:

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1. "Family doctors are not trained well enough to take care of this responsibility."[3]

This contention might be partly true, for family physicians taught obstetrics by routinely interventional obstetricians or family physicians (usually trained using a maximin-strategy or worst-case[35,37] philosophy) can be made to feel helpless and incompetent. The "bomb-squad approach"[1,3,35] to maternity care, which asserts that "every pregnant woman is a time bomb ready to go off and (needs a) bomb disposal squad,"[3] is to most family physicians dissatisfying, unsafe, and unsatisfactory, particularly for the provision of routine family-centered maternity care.[3,11,14,15,40,60,65-82]

If, however, family physicians can be trained either by physicians or midwives who practice "family-centered birthing"[15] and can be trained in more appropriate birthing environments, then they might be better prepared to practice a birthing care that is noninterventional, safe, and satisfying.* To date, all studies of noninterventional maternity care have shown excellent outcomes when compared with routinely interventional techniques.† In addition, many women prefer the expectant approach provided by most family physicians and midwives, which has been called "low-tech, high-touch care."‡ Consequently, we join others[9,11-13,107] in believing that in most situations family physicians should be taught maternity care by physicians or midwives who believe and practice a family-centered birthing that appropriately uses intervention only when indicated. To continue to utilize maternity care instructors or role models whose obstetric care philosophy is physician and disease centered and whose interventional techniques are potentially deleterious to maternity patients is detrimental to our discipline, our learners, and to our patients and could represent a form of educational malpractice and malfeasance.

2. A fashionable second argument against family physicians participating in maternity care is that "midwives could offer better care than the average family physician, and what midwives cannot do can be done by the obstetrician-gynecologist."[3,109]

*Refs 10,11,14,15,48,55,67-70,72,73,76,78,79,81,83
†Refs 40,41,46,47,65,66,68-71,80-104
‡Refs 9-11,15,48,67,72,99,105,106

This view, along with the maternity care access problem experienced by rural, inner-city, and underserved populations, has led at least one state to pass special legislation to certify lay midwives to practice in the state's rural areas, even though family physicians are already located in those areas.[79,109] The provision of most or all rural prenatal care by midwives is a goal that, for a number of reasons, might not be attainable.[109-111] Is there another option? Would rural family physicians who provide neither prenatal nor intrapartum care provide at least prenatal care if encouraged? One state study has indicated they would if perceived or actual reimbursement, practice protocol, and malpractice insurance cost obstacles could be overcome.[109]

In some countries midwives provide most of the obstetric care; however, for many reasons this practice has not yet developed in the United States and is believed by some to be unlikely to develop to any large extent in the near future.[3,32,33,109,111] Despite the philosophy and skills that midwives bring to maternity care, most are not in private practice, are not located in rural or inner-city areas, usually have no previous knowledge of the woman or her family, and do not provide ongoing care to the newborn child.[3,109] Unlike family physicians, most midwives are not trained in labor induction or augmentation, vacuum-assisted birth, broad-based medical care, prescribing medications, neonatal resuscitation or intubation, and so on.[3] Most family physicians are trained to provide these services, are much more likely to be distributed into areas of actual need, and have excellent perinatal outcomes.[108,112-114]

That said, we do not believe that rural and inner-city maternity care in the United States can or should be provided only by family physicians or midwives alone, or that all suburban and urban maternity care should be provided by obstetricians only, but that the ideal public policy would plan for and encourage the provision of family- and patient-centered maternity care by skillfully interweaving and valuing each provider group.[23,33,44,108,109]

3. Perhaps the most uninformed argument is that "family physicians have nothing unique to offer the childbearing woman."[3]

Evidence from the medical literature would support a view that family physicians have

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much to offer women in childbirth.* Studies have revealed that low-risk women cared for by family physicians have equal or better outcomes than do similar women cared for by obstetricians,[46,47,65,69,70,80-83,92-98] that Cesarean section rates are highest where obstetricians give primary care,[80-82,104,105,116,117] that family physicians are more likely to provide noninterventional maternity care,[83,92-99,106] and that family physicians and midwives have similar outstanding outcomes.[108] Furthermore, family physicians provide primary care at a lower cost than do other physicians.[118-120]

4. A philosophy often taught to medical students and residents is that "obstetrics is a very risky business, indeed!"[3,35-37]

Admittedly, maternity care has an element of uncertainty; however, maternal death and serious disability occur rarely in family-practice–attended labor.[121,122] When perinatal mortality or severe disability does occur, it is usually related to congenital abnormality or other prenatal or environmental or genetic factors over which family physicians have little or no control.[123,124] Furthermore, those emergent and infrequent intrapartum problems that can and do occur can be managed successfully with easily learned and practiced protocols, such as those used in the Advanced Life Support in Obstetrics (ALSO) course. An ALSO course can increase a learner's or practitioner's confidence and practical skills in infrequently encountered events in much the same way other advanced training courses can, such as Advanced Cardiac Life Support, Advanced Trauma Life Support, Pediatric Advanced Life Support, Neonatal Advanced Life Support (personal communication from James Damos, MD, co-originator of the ALSO course). In addition, family physicians are much less likely to be sued for the obstetric portion of their practices when compared with the nonobstetric portion.[14,79,121,122]

Why Family Physicians Should Do (Person- or Patient-centered) Maternity Care

Family physicians as a group might have as much or more to offer in providing person-centered maternity care as any other group of maternity care providers:

1. Based in the community, family physicians are already available in nearly every county of the United States.[109-111,115,125] Family physicians are specifically trained to understand community needs and to promote provider and facility sensitivity to community concerns, so that health care in general and routine maternity care in particular are humanized.[1,3,11,12,15,27,75]
2. Family physicians are by the very character of their discipline more tolerant of ambiguity or uncertainty, and by nature and training they have less need to exert control over their patients.[2,3,9,11,15] These personal characteristics are essential for a thoughtful, rational, and successful approach to birthing.[15,34,67,72,100,101]
3. Perhaps the most important factor that supports the belief that family physicians have something particular to offer maternity patients is that women are still choosing family physicians to provide care for them during labor.[1,11,15,33,48,60,75,115,125] In communities where there are enough obstetrician-gynecologists or midwives to care for all of the pregnant women, women continue to ask obstetrically active family physicians to be their physician and their baby's physician.[3,89] By doing so, these women demonstrate their belief that family physicians have something special to offer. Simply put, family physicians should continue to provide maternity care as long as women continue to choose them for this service.
4. Finally, and most worrisome, family physicians in rural locations, by choosing not to provide maternity care, might be contributing to an increase in the infant death rate. First recognized in rural Indiana,[118] evidence now appears in rural Florida that when a family physician chooses not to provide maternity care, this decision is associated with an increased infant death rate (unpublished data from one of our (WLL) research projects). If these data reflect a cause-and-effect phenomena, and if medicine as a profession is truly concerned about maternal-fetal health, then we must insist that family

*Refs 1-5,8-20,23,27,30,38-40,46-48,62,65,67,69,70,73,75,83,92-106,112-115

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physicians remain involved in or become involved in birth care, at least in rural and underserved areas.[23,56,126] Academic family medicine and organized family practice must train, enable, equip, and encourage family physicians to provide maternity care. To not do so is, in our opinion, illogical and unconscionable.

Who Should Provide Maternity Care in the Future?

There are at least six groups who should be involved in providing maternity care in the future.[1,3,9,126] Each group has its particular strengths, and each group would benefit from working closely and in cooperation with the others:

1. First and foremost are the women who are having babies. They need to be better informed, healthier, and more independent so they can give birth to their children with the kind of support and assistance that they and their families think best.[3,15,29,67,85,87-91,100] These women must be encouraged, equipped, and enabled, without unnecessary and nonindicated intervention, to complete one of the most essential roles given to them, to birth their children. Any aspect of their care during pregnancy, labor, or delivery "for which safety benefits are small or unproved should remain subject to the choices and preferences of the woman giving birth."[100]
2. There will always be a need in the United States for a group of committed, well-trained, adaptable, supportive obstetric nurses who provide care during labor and childbirth. They will need to be particularly adept at recognizing deviations from normal. These coproviders of obstetric care have been trained to step back from the woman and to depend on electronic devices and laboratory tests.[87,88] They will need to recover their skills of touching, standing-by, and being with. They need to learn, along with family physicians and obstetricians, that being present can often be more important than doing something.[84-90]
3. The doula, a skilled and experienced laywoman who acts as a support companion, should be an indispensable part of future labor care.[84-88] These women of special understanding and talent are committed to encouraging, supporting, and not abandoning women in labor.[85,88] These community-based servers-observers are usually multiparous women whose main training is experience and whose main qualification is their female sex.[3,29,88] These women, by their presence and touch, should help reduce the need for Cesarean deliveries, epidural anesthesia, analgesia, and oxytocin, as well as reduce the duration of labor and fetal and maternal morbidity.[84,85,88] It is possible that there is no more cost-effective or simpler strategy to improve the health of laboring women than using the doula.[88] It is also possible that obstetric nurses or midwives can provide for or contribute to this doula effect.[88-91,108]
4. Midwives and family physicians have philosophical and practice styles that are similar and maternity care outcomes that are remarkably similar.[9,33,108] Some forward-thinkers have encouraged closer working relationships between midwives and family physicians.[9,33] The potential advantages are numerous and the disadvantages more imagined than real. For family practice residencies struggling to recruit family practice faculty, especially those faculty with an interest and expertise in family-centered birthing, midwives can offer economic, philosophic, and practical benefits. As health system reform in the United States continues to evolve, it appears that midlevel practitioners will play an even greater role. It is past time for family practice as a specialty and family medicine as an academic discipline to assert a leadership position in shifting the paradigm of maternity care to increase collaboration between family physicians and midwives.
5. Consultant specialists, whether obstetrician-gynecologists, perinatologists, anesthesiologists, or neonatologists, will always be needed and valued by family physicians and their patients. Their competence, skills, and special knowledge are vital to primary care physicians. They will, however, need to be sufficiently knowledgeable about and confident in family practice to allow family physicians a place in the delivery of maternity care, particularly for routine maternity care.

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6. Finally, there is a growing need for family physicians to manage and coordinate their patients' maternity care: family physicians who will maintain a commitment to humanized family-centered childbirth facilities, who will advise women in labor when intervention might be indicated and when it is not, who will be rooted in the community and attentive to and sensitive to the community's desires and needs, who will be attuned to the difference between what is normal and what is seriously abnormal. They will be knowledgeable in obstetric crisis management; and they will have been trained by family physicians or midwives in a philosophy of noninterventional, patient-centered, not facility-centered, maternity care and birthing based upon the view that birth, a life event, more often than not needs practitioners who are adept at the ancient art of "doing nothing." They will know when it is suitable "to do nothing," and when they are appropriately "doing nothing," will do it well. In fact, they will know how to "do nothing" extremely well.

Family Practice Maternity Care — Will the Endangered Species Be Saved?

If maternity care in family practice is to survive and grow, we need to offer society appropriately trained, caring, family physicians who are by their temperament and training committed to families and to the community. These family physicians will need to be well-educated and confident in their family-centered birthing care skills. They will need to have been trained by physicians and midwives who share, model, and transmit this unique philosophy and these special skills. These physicians will need to understand not only the science of childbirth, but more importantly, they will need to appreciate its art and be alert to the profoundly mysterious, even spiritual nature of birth. Then family physicians could be among the most qualified maternity care providers in the United States. As a result, more women will be enabled to birth, with improved outcomes in terms of maternal, child, family, and community health.

Just as the midwives of ancient Egypt were true to their calling to do what was right rather than what was politically expedient, to do what was right rather than what was convenient, to do what was right rather than what was expected, so should today's family physicians. As physician descendants of the midwives of old and potential allies and colleagues of the modern midwife, family physicians should restore their commitment to the person-centered delivery of childbirth care, for the sake of the women of today and the children of tomorrow.

Does family practice have a place in future maternity care in the United States? Absolutely! For we believe that without family physicians, maternity care cannot be all that it should be! Despite the exodus of family physicians from maternity care, immediate action by organized family practice, academic family medicine, and individual family physicians could well bring family-centered birthing into the mainstream of family practice in the United States.

Birthing is intrinsic to the formation of the family, and "family medicine without birthing is not family medicine, it is just medicine."[15] The many benefits of maternity care in family practice are being discovered, and the so-called "risks" are being critically reevaluated.*

Family physicians who deliver babies are still an endangered species, but clearly a species in our genus (of family practice) worth saving.[1,10-15,18] Although this species could survive most anywhere should it decide to do so, it appears to have distinct ecologic niches. Its inherent peaceful nature requires it to be nurtured in appropriately peaceful and supportive environments if it is to be expected to reproduce.[15] After a critical mass has been reached, it will then be possible to release into selected and more difficult areas of the technological medical environment particularly robust and tough-skinned members of the species, so as to expand its niche. Thereafter, there might begin a natural and inevitable spread of this essential and indispensable species across the United States. The members of this species, obstetrically competent family physicians, will be confident in their acceptance and acknowledgment that while birth can never be fully known or understood, it can be experienced with dignity, trust, satisfaction, and joy.

We believe this species has been unnecessarily endangered by acts of both commission and omis-

*Refs 4-5,13-15,20,23,40,72,73,78,79,99,105,106,112,115

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sion by physicians both in and out of the specialty. We believe this species is essential to the specialty and is worth saving. We believe that dramatically increasing the population of this species in the United States is valuable to family, maternal, fetal, and child health care in the United States. We believe this species, with the commitment of family medicine educators, can both grow in numbers and disperse geographically. We believe that this species, if abandoned by family medicine educators, will become extinct and the entire genus will be irreparably harmed. We believe that as the species enlarges, family practice as a specialty and a profession will become even more satisfying, diverse, and enriched and that birth will be healthier and more gratifying for those childbearing women who honor family physicians by choosing us to attend and participate in *their* births.

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