obstetric team on call. Women with problems will have also received midwifery care but can have a seamless transition to an obstetrician. I believe that there could be no criticism of such a model unless there is a hidden agenda.

Hidden agenda

As in many other areas of medicine obstetricians have introduced monitoring and interventionalist strategies to the management of pregnancy and labour without full scientific evaluation. This has led to a medicalisation of normal pregnancy and resulted in an increase in the rate of induction and caesarean sections, many of which could be classified as unnecessary. The hidden agenda of those who propose that obstetricians should not see women with normal pregnancies is not continuity of care and extended choice for women but rather to reduce the level of intervention by keeping women away from obstetricians. It would be much better if women, midwives, and obstetricians all acknowledged that a problem exists. The appropriate studies could then be done to determine which interventions are required for the safest and most acceptable care. If nothing else this approach would have the advantage of being intellectually honest.

Uniting the professions

Finally, and perhaps most persuasively, the main reason that women should not be cared for only by midwives is that it will drive a wedge between midwives and obstetricians. Obstetricians need the help and support of midwives throughout their career. From instruction in normal labour and delivery in medical school to shared responsibility on the labour ward and in the clinic in later life the two professional groups should work hand in hand. When things go well and when outcomes are unexpectedly poor both groups need that mutual support. If obstetricians do not see normal pregnancies we run the severe risk of ending this tradition of cooperation to the detriment of everyone, especially pregnant women.

Whose decision?

In the end though, who should decide? Well intentioned politicians and their select committees, prey as always to the biased views of well organised lobbyists?[4] Those who some call modern obstetricians but who are in fact antenatal paediatricians who not unreasonably have limited interest in normal women? Should it be radical midwives wishing to extend their own sphere of influence or feminists working to their own political agenda? Should it be paternalist obstetricians attempting to save their roles and their view of a changing world? No, none of these. The choice should be left to pregnant women themselves. If they are asked the appropriate question: "Do you wish to be looked after by a team of carers, including both midwives and doctors whom you will meet during the course of your pregnancy and who will work together to provide care for you whether your pregnancy is complicated or not?" They will answer yes. If they are appropriately informed pregnant women would say that obstetricians should see normal pregnancies.

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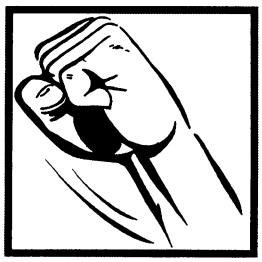
2 *Changing childbirth: the report of the expert maternity group.* London: RCOG, 1993. (President's letter.)
3 Street P, Gannon MJ, Holt EM. Community obstetrics care in West Berkshire. *BMJ* 1991;**302**:698-700.
4 Steer PJ. House of Commons Health Committee report on the maternity services. A personal view. *Br J Obstet Gynaecol* 1992;**99**:415-46.

Obstetricians should focus on problems

David K James



The provision of care for pregnant women is changing enormously. Many of these changes were under way before the well publicised Winterton and Cumberlege reports.[1,2] One of the changes is that women with normal pregnancies increasingly see their general practitioner and midwife for most of their care and see the obstetrician less often. In some instances women do not see an obstetrician at all. I think that this trend is to be encouraged. I believe that in the ideal world women with normal pregnancies need not see an obstetrician for four reasons—consumer, philosophical, scientific, and evolutionary.

Consumer argument

Several studies have shown that most women with normal pregnancies do not wish to see an obstetrician.[3-6] Naturally, it is difficult for such studies to be free of bias. It depends who asks the questions, how they are asked, and how they are phrased. Nevertheless, I am not aware of any survey which claimed that most women would wish to see an obstetrician if their pregnancy were normal.

Philosophical argument

Care in pregnancy has four aims (box).[7] General practitioners and midwives are perfectly able to fulfil the first three aims (providing reassurance, treatment of minor problems, and undertaking screening). There is no evidence that obstetricians are any better at performing these functions in otherwise normal pregnancies. In contrast, women with problems in pregnancy require the skills of an obstetrician, and it is at these women that an obstetrician's efforts are best directed.[8]

Scientific argument

Controlled studies have shown that the outcome of women with normal pregnancies seen by an obstetrician is no better than that when no obstetricians are involved.[9,10] It should be stressed, however, that in such studies the normal pregnancies were managed

Aims of care in pregnancy[7]

1 To provide advice, reassurance, education, and support for the woman and her family

2 To deal with the minor ailments of pregnancy

3 To provide an ongoing screening programme (clinical and laboratory based) to confirm that the woman continues not be at risk

4 To prevent, detect, and manage those problems and factors that adversely affect the health of the mother or her baby

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Commentary: recognise the different strengths

For most women pregnancy is a physiological process complicated at worst by minor and easily managed symptoms. For a minority the pregnancy becomes anything but normal, with substantial morbidity or mortality for the baby and sometimes for the mother. The point of antenatal care is to identify those at risk and concentrate resources on them. I am not persuaded that highly skilled obstetricians are needed to decide that a pregnancy is normal. However, a corollary of obstetricians not seeing normal pregnancies is that midwives and general practitioners must be alert to the features of impending problems that would require an obstetrician's expertise. It would be a tragedy if political manoeuvring led to particular groups behaving as if they "owned" pregnant women, since this would only diminish the quality of obstetric care. Everyone who cares for pregnant women has something different to offer. The very best midwives, family doctors, and obstetricians are those who recognise their limitations as well as their strengths.—PETER C RUBIN, *professor of therapeutics, University of Nottingham*

following clearly documented guidelines for identification of risk and referral for obstetric review should problems be recognised.

Evolutionary argument

Obstetricians should have and develop skills that are different from those of general practitioners and midwives. These skills are those which at present are regretfully seen as the province of the subspecialist. Thus obstetricians in future should be expected to have expertise in ultrasound evaluation of the fetus, care of the more routine medical problems without immediate reference to a physician, and high dependency obstetric management.

In addition, all obstetricians should take part to some degree in clinical audit and research. This is more likely to have a multicentre basis. For example, there is a pressing need for the development of new methods of screening for fetal compromise in normal pregnancies. It is hardly surprising that over half of fetal deaths are unexplained when current fetal screening comprises only monitoring of fetal activity, measurement of fundal height, and auscultation of the fetal heart.

Conclusion

In an ideal world women with normal pregnancies should not see an obstetrician. Most do not want to, and they do not need to. Obstetricians should be concentrating their skills on women with problems. Pregnant women should see medical professionals according to their clinical needs and individual wishes. The general practitioner, midwife, and obstetrician represent the professional team responsible for providing care for all pregnant women. Though obstetricians need not provide care for normal pregnancies they should have a role in the interdisciplinary planning and audit of such care. General practitioners and midwives should share responsibility for caring for women with normal pregnancies—not the midwife alone. Each has skills that the other does not possess. They should not duplicate each other's efforts but complement them.

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TWO MEMORABLE PATIENTS

Obstetric tetanus

In the early 1960s, when I was a general practitioner in the southern suburbs of Sydney, a 42 year old woman attended my surgery and surprised me by saying that she thought she had tetanus. When I examined her she did have a stiff jaw and other early signs; further questioning revealed a sad story. Though married, she had devoted her life to rearing her sister's two children, the parents having been killed in a road accident. When the children were old enough she decided to have a child of her own. But when she became pregnant she was persuaded by a friend that she was too old to have children and went to a backyard abortionist.

Admitted to the local public hospital (now a thriving teaching hospital of the University of New South Wales) there was initial resistance to the diagnosis and an attempt to remove her from my care. I engaged a multidisciplinary team. The senior gynaecologist performed a hysterectomy, a tracheostomy was performed, and the senior physician put her on heparin to prevent venous thrombosis. After three weeks in the recovery ward we seemed to be winning, the tetanus subsided and the tracheostomy was removed. Then she coughed up a little blood; the physician promptly stopped the heparin and within 24 hours she died from a major pulmonary embolism.

In 1968, now a consultant surgeon on the staff of the same hospital, I spent three months in a civilian hospital in Vung Tau, South Vietnam, during the conflict. The medical and surgical services of the hospital were conducted by an Australian medical team, the obstetric services were under the care of the Vietnamese doctors. We did caesarean sections for them when asked, and on one occasion we were presented with a patient with puerperal tetanus. She, too, had a tracheostomy, but only a uterine curette was carried out. She had antitetanus serum, intravenous diazepam, steroids, and antibiotics. Because of the curfew only her relatives were present to look after her at night. She recovered and eventually made her way into the *Medical Journal of Australia.*[1]—K B ORR *is a surgeon in Sydney, Australia*

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