

Exploring family physicians' reasons to continue or discontinue providing intrapartum care

Qualitative descriptive study

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Abstract

Objective To examine the reasons why family physicians continue or discontinue providing intrapartum care in their clinical practice.

Design Qualitative descriptive study.

Setting Two hospitals located in a multicultural area of Montreal, Que, in November 2011 to June 2012.

Participants Sixteen family physicians who were current or former providers of obstetric care.

Methods Data were collected using semistructured qualitative interviews. Thematic analysis was used to analyze the interview transcripts.

Main findings Three overarching themes that help create understanding of why family doctors continue to provide obstetric care were identified: their attraction, often initiated by role models early in their careers, to practising complete continuity of care and accompanying patients in a special moment in their lives; the personal, family, and organizational pressures experienced while pursuing a family medicine career that includes obstetrics; and their ongoing reflection about continuing to practise obstetrics.

EDITOR'S KEY POINTS

- While a decreasing percentage of births in Canada are attended by family physicians, the individual motivations that sustain family physicians' decisions to practise obstetrics remain largely unexplored.
- This study aimed to determine how family physicians explain their decision to continue or discontinue providing obstetric care as part of their clinical practice.
- Participants were generally attracted to the practice of obstetrics early in their careers, and they found the opportunity to accompany patients throughout their lives appealing. Those providing intrapartum care take into account personal, family, and organizational factors that inform their decision to continue or discontinue providing such care. Providers are in a perpetual process of reflection about their decision, whether they have continued providing intrapartum care or not.

This article has been peer reviewed.
Can Fam Physician 2017;63:e387-93

Conclusion The practice of obstetrics was very attractive to family physician participants whether they provided intrapartum care or decided to stop. More professional support and incentives might help keep family doctors practising obstetrics.

Les raisons pour lesquelles des médecins de famille continuent ou cessent de prodiguer des soins liés à l'accouchement

Une étude descriptive qualitative

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Résumé

Objectif Déterminer les raisons pour lesquelles des médecins de famille (MF) continuent ou cessent d'offrir des soins obstétricaux.

Type d'étude Une étude descriptive qualitative.

Contexte Deux hôpitaux d'un quartier multiculturel de Montréal, au Québec, entre novembre 2011 et juin 2012.

Participants Seize MF qui offraient ou avaient déjà offert des soins obstétricaux.

Méthodes Les données ont été recueillies à l'aide d'entrevues qualitatives semi-structurées. On s'est servi d'une analyse thématique pour analyser les transcrits des entrevues.

Principales observations On a identifié des thèmes primordiaux qui aident à comprendre les raisons pour lesquelles des MF continuent d'offrir des soins obstétricaux: un intérêt particulier, souvent déclenché par des modèles de rôle tôt dans leur carrière, incitant à fournir des soins véritablement continus et à accompagner leurs patientes dans des moments spéciaux de leurs vies; les pressions d'ordre personnel, familial et organisationnel qu'ils subissent au cours d'une carrière en médecine familiale comportant de l'obstétrique; et les questions qu'ils se posent constamment pour savoir s'ils vont continuer ce type de pratique.

Conclusion Les MF participants avaient beaucoup d'intérêt pour la pratique obstétricale, qu'ils en fassent ou non. Davantage de soutien professionnel et d'encouragements pourraient inciter les MF à continuer d'offrir ce type de pratique.

POINTS DE REPÈRE DU RÉDACTEUR

- Alors qu'il y a de moins en moins de médecins de famille (MF) qui font des accouchements au Canada, les raisons pour lesquelles certains d'entre eux décident d'en faire demeurent en grande partie inconnues.
- Cette l'étude voulait connaître les raisons pour lesquelles les MF décident de continuer ou de cesser d'offrir des soins obstétricaux à leurs patientes.
- En général, c'est en début de carrière que les participants avaient été attirés par les soins obstétricaux, une décision qui leur permettrait d'accompagner leurs patientes tout au long de leur vie. Ceux qui décident d'offrir des soins de cette nature tiennent compte de facteurs d'ordre personnel, familial et organisationnel, lesquels jouent un rôle important dans leur décision. Et quelle que soit leur décision, ils la remettent constamment en question.

Cet article a fait l'objet d'une révision par des pairs.
Can Fam Physician 2017;63:e387-93

Obstetrics, and specifically intrapartum care, have traditionally been an integral component of family practice in North America.¹ Nevertheless, the percentage of births attended by family physicians has declined in recent decades. In 1983, about 68% of Canadian family physicians reported attending deliveries²; this percentage dropped to about 20% by 1997 and to 10.5% in 2010.³⁻⁵ A similar pattern has been observed in the United States, where 43% of family physicians provided intrapartum care in 1986, compared with only 28% in 2006.⁴ This declining trend raises concerns about access to skilled birth attendants, particularly for women in rural and underserved regions^{3,4}; a lack of continuity in maternity and newborn care^{3,4}; and a possible increase in specialized care with potential overmedicalization of births.^{6,7}

Previous research has investigated the possible driving forces behind this phenomenon, including factors that influence the choice of learners to include obstetric care in their practices,⁸⁻¹⁰ the effects of medical liability on physicians' career choices,¹¹ the effects of attending deliveries on office family practice management,¹² and the effects of workload, sleep deprivation, and other external factors on physicians' career choice.^{13,14} Overall, this body of research concludes that logistic and financial considerations are contextual factors that tend to discourage the practice of obstetrics by family physicians.

In more general terms, research also shows that graduates increasingly report that being "lifestyle friendly" is an important criterion when choosing a specialty—a criterion that is not in line with the current practice and structure of obstetric care.¹⁵⁻¹⁸

While there is a sizable body of research that has examined contextual influences on family physicians' practice of obstetrics, the internal motivation that causes family physicians to decide to discontinue practising obstetrics or to continue practising in spite of the challenging context, remains largely unexplored.⁵

To address this gap, we examined how family physicians explain their decisions to continue or discontinue providing obstetric care as part of their clinical practice in order to better understand the rationale for family physicians' decisions about obstetric practice and to inform future policies on family practice obstetric care.

METHODS

Research design

We adopted a qualitative descriptive research design, which allows the researcher to obtain simple and direct answers to questions of special relevance to practitioners and policy makers.^{19,20}

Participants and sampling strategy

Participants in the study were family physicians who

were either providing obstetric care during the period of data collection (November 2011 to June 2012) or who had ceased the practice in the 5 years before data collection. Family physicians were recruited from 2 university-affiliated hospitals (H1 and H2) located in a multicultural area of Montreal, Que. The hospital catchment area serves many recent immigrants and refugees who are overrepresented among the socioeconomically and medically vulnerable. The hospitals differed in certain characteristics; specifically, H1 was a larger specialized centre, and H2 was a smaller community hospital. Participants were recruited using purposive maximum variation sampling²¹ to optimize the range of practice experiences and individual characteristics (sex, age, number of years of practice) likely to play a role in the decision to continue or discontinue intrapartum care. A total of 16 family physicians (3 male and 13 female), who were all members of their hospitals' on-call groups, participated in the study. The sociodemographic characteristics of participants are outlined in **Table 1**.

Data collection

Data were collected using individual semistructured interviews. Face-to-face interviews were conducted with 9 participants; 7 participants were interviewed by telephone. Before the interviews, participants provided written informed consent. All the interviews were conducted by the second author (M.J.D.) and they lasted 20 minutes on average. The interviews were audiorecorded, transcribed verbatim by a clerical staff member, anonymized, and checked for accuracy by the first author (M.D.).

Data analysis

Semantic thematic analysis²² was performed on the interview transcripts using NVivo 10 software. Data were analyzed both deductively using initial codes inspired by the literature and inductively to allow new codes to emerge from the analysis. To ensure rigour in coding and analysis, a subset of 6 randomly chosen transcripts were independently coded by the first and second authors. The 3 co-authors used iterative cycles to identify and discuss emerging themes and the linkages among themes, and to draw conclusions about the meaning of those themes.

Ethics approval was obtained from the McGill University Faculty of Medicine Institutional Review Board before conducting the study.

FINDINGS

Themes

We identified 3 main themes that help us understand why family physicians decide to continue or discontinue providing intrapartum care.

Table 1. Participant characteristics

PARTICIPANT CODE	SEX	AGE GROUP, Y	HOSPITAL	STILL PRACTISING IPC	YEARS IN PRACTICE
FP01	Female	30–39	H1	Yes	10
FP02	Female	30–39	H1	Yes	8
FP03	Female	30–39	H1	No	9
FP04	Male	40–49	H1	No	9
FP05	Female	30–39	H1	Yes	3
FP06	Female	60–69	H1	No	30
FP07	Female	40–49	H1	No	15
FP08	Female	60–69	H2	No	38
FP09	Female	20–29	H2	Yes	1
FP10	Female	40–49	H1	Yes	14
FP11	Female	30–39	H1	Yes	4
FP12	Female	50–59	H1	Yes	20
FP13	Female	40–49	H1	Yes	11
FP14	Female	60–69	H1	Yes	40
FP15	Male	30–39	H2	Yes	3
FP16	Male	40–49	H1	No	13

IPC—intrapartum care.

Attractiveness of the practice of obstetrics. Providing obstetric care was very attractive to participant family doctors, especially at the beginning of their careers. Reasons provided to justify this interest included the presence of inspirational role models, particularly during the residency period, and the opportunity to provide continuous care.

I think I had several role models. Like I said, I did obstetrics training at the same place where I am working now, and I had many different teachers who are now all my colleagues and who were very encouraging that I do obstetrics, and they sort of modeled good work-life balance as well as good patient care.

I think it is a very balanced thing to be a clinician, a family physician, who is able to incorporate obstetrics into the practice. Because you get that hospital feel, there is a little bit of a surgical component to it. And you really get to be very connected with your patient. It is probably the only part of medicine where you are giving the most continuity of care. I mean here you take a woman who, before she becomes pregnant, so preconception, and you follow her throughout pregnancy. You are there for the delivery. You are following her child.

Particular interest in women’s health and in serving diverse or vulnerable populations were additional reasons given for choosing to practise obstetrics. Further, a number of participants were attracted by the vocation of teaching, which allowed them to model their practice to future generations, and the hands-on nature of the

practice of obstetrics. The uniqueness of the birth experience, an interest in caring for people at all stages of the life cycle, and an interest in practising noninterventionist obstetrics or a more humanized model of care, were other reasons given for the choice to practise.

I believed in incorporating the entire life cycle into my practice—that is from conception all the way to death—and in order to be consistent with that, I wanted to have obstetrical care as part of my practice. And particularly, I enjoyed the intense life cycle moments such as birth and death. So doing deliveries was my hope to be able to participate in that.

Birth is a moment of transfiguration and sometimes of transcendence, so to me it is the time. Now I guess people who do palliative care and who help people go the other way, maybe that’s why they stay there, because it is this thirst for something mysterious and sacred. But I am not sure whether you can find it elsewhere. Outside of the 2 ends of life, you know?

Perception of personal, family, and organizational demands. Despite their genuine interest in the practice of obstetrics, participants pointed to a number of issues that discouraged them from continuing to provide intrapartum care. First, aging appeared to be a personal circumstance that made the practice of obstetric care more physically challenging.

I really loved my practice! I currently follow my pregnant patients up to the last month and then I sign them over to members of my group. When I say goodbye, I have this momentary regret, but it felt like

it was time (because of my age). I found that being up all night and then trying to recover, it just sucked up too much energy.

Second, for some the practice of obstetrics itself made participants question their competency to practise.

I stopped because I was not enjoying it. It was emotionally difficult and confusing and challenging. I was also getting anxious about being involved in the process. I also did not feel very confident in my skill set. Over time, while I think my skill set actually improved, my confidence level didn't and I was tired of feeling incompetent.

In this regard, experiencing a negative maternal or neonatal outcome could be a triggering event for a family physician to abandon the practice of obstetrics:

Well I think for a lot of us when there is a bad outcome it is always difficult to deal with it. Some people decide to quit after that. Sometimes we become, we practise, a little bit more defensively after that.

I believe that if I had a really bad outcome, it might have a strong impact, especially if that bad outcome was early on into my career. I think it would have had a potentially big influence and make me reconsider if I want to do it at all. I guess I've been lucky; I haven't really had anything [happen] that has been that catastrophic.

Additionally, particular family circumstances either encouraged (eg, supportive partners) or discouraged (eg, parental imperatives) the practice of obstetrics.

My husband is very supportive of obstetrics, the way that I do it. I think if that were to change, then I would be forced out Then the reason that I would stop is because [of] the lack of support of my husband.

After I started going back to being on call, when my [child] was small, I would only do 12 hours because I couldn't stay awake for longer, because towards the end of those 12 hours, if I was still in the hospital, I would be falling asleep. Literally! So one of my main decisions was, "I am not doing any patients any good by being asleep on call." I was not as sharp. I didn't make any mistakes but I could have. So that's one reason why I said no more.

Indeed, the working conditions in which family physicians provide intrapartum care were an important influence on the decision about whether or not to practise obstetrics. As the physicians participating in this study noted, working in a clinical team that shared the same philosophy of practice and that allowed flexible

schedules enabled them to combine their family and work lives and continue to practise.

We have this common passion for obstetrics. It is really an interest and it's a common denominator, which really keeps us happy together; we have a similar approach to seeing patients.

The group that I work with allows us to be very flexible in our schedule. So in terms of having a family and being able to continue doing that, it is still very feasible. And I still enjoy it as much as I did when I started. So that aspect I don't think will change. But the flexibility of the group and being able to cut down a little bit is very beneficial.

On the contrary, interprofessional tensions, for instance with obstetricians and with policy makers, who in this case determined the number of deliveries allowed for a practice group, could be deterring.

I think it does discourage a lot of people from doing it. I was intimidated. I wasn't intimidated by the kind of practice I had; I was intimidated by the fact that they wanted us to do less deliveries. Because there is the matter of prestige and there is the matter of the pay at the end of the day. And so I was constantly being harassed: "You have to see fewer patients."

Ongoing process of decision making about providing intrapartum care. Even if they made the decision to stop practising, participants in this study recognized that they were continuously involved in a process of reflection about their obstetric practice.

I am always reconsidering it in my mind and testing coming back to obstetrics. I would like to say that I am always reconsidering it. But, at the present time, I don't see it happening at this stage of my family life cycle.

This perpetual reflection yielded 4 different types of resolutions: permanent cessation, temporary cessation, continuing practising as usual, or continuing practising with some modifications. In this last regard, the most common modification cited was discontinuing intrapartum care while continuing the follow-up of pregnant women.

I still follow prenatal patients in my office. I still do postpartum care and prenatal care. I basically just don't do the part where I have to come in to the hospital and do the delivery. But everything else I am still doing. I work at the breastfeeding clinic.

DISCUSSION

Consistent with previous research that highlights a

strong interest among young family physicians in the practice of obstetrics, our findings show that participants were attracted to the practice from the beginning of their careers.^{9,23} Our work also shows that whether or not family physicians continued practising intrapartum care, they remained attracted to this clinical practice because of the unique opportunity it offers to accompany patients throughout their lives.

In addition, our study shows that family physicians who decide to provide intrapartum care will take into account a constellation of personal, family, and organizational factors that will inform their decision to continue or discontinue this practice as time goes by. In this regard, the participants discussed their need for a supportive team offering flexible scheduling in order to respond to the needs and imperatives of partnership and family life. One of the hospital groups, for example, allowed members to contribute fewer shifts or only particular types of shifts to the on-call schedule under certain personal circumstances. Participants also pointed to an ongoing need to maintain or build their skills through continuing professional development; the importance of a positive work climate with other health care professionals and with policy makers; and the need for targeted support for physicians who experience a negative clinical outcome, particularly early in their careers. In this regard, our findings further suggest that the size of the hospital setting in which family physicians practise and their organizational climate might influence the nature and level of interprofessional relations, with the smaller community hospital setting possibly facilitating interpersonal exchanges and teamwork better than the larger specialty hospital.

The complex and dynamic nature of family physicians' decision making with regard to intrapartum care is further evidenced by a third important finding of this study, which is that these professionals appear to be in a perpetual process of reflection about their decision to provide intrapartum care, whether or not they have continued or discontinued the practice of obstetrics. It is important to note that those who have discontinued the provision of intrapartum care still report a passion for this type of clinical work.

Limitations

This study has several limitations. First, the investigation included only 16 participants; more interpretive research is needed to further explain these complex decision-making processes. Second, participants were recruited from 2 hospitals, limiting the scope of influence of health care organization dimensions (eg, the degree of specialization and its accompanying climate or the set-up of the on-call schedule) on decision making. Finally, most of the participants were women; further studies are needed to delve into the understanding of sex and gender issues with regard to the decision-making processes in this context.

Implications for clinical practice and future research

This study makes a number of contributions to a better understanding of family physicians' obstetric practice. First it suggests that the decision to continue or stop this practice is a complex and dynamic process that evolves over time and that it is not limited to a single moment or event. Family physicians often decide to provide obstetric care at the onset of their professional careers, and a number of personal, family, and organizational dimensions can positively or negatively influence the continuation of this practice. Health care organizational managers and policy decision makers who recognize that family physicians practising obstetrics are a specific group that must be nurtured to avoid problems of access to care, to support continuity of care, and to limit overmedicalization of care could consider the following measures:

- facilitate the balance between family life and comprehensive professional practice (eg, by promoting flexible on-call schedules);
- ensure that physicians have sufficient opportunities for maintenance of competence in obstetrics, including the ability to attend an adequate number of deliveries in their hospital setting;
- assist both individual physicians and their groups to deal with the emotional consequences of a poor obstetric clinical outcome, ideally enabling them to learn and grow from the experience;
- identify interprofessional tensions and establish official mechanisms for managing them;
- encourage teamwork in health care delivery to promote positive interprofessional relationships; and
- foster faculty development by encouraging regular reflective sessions for family physicians to assess their practice patterns and balance their personal pressures with their professional requirements, explore opportunities for ongoing learning, and develop personalized portfolios focused on long-term professional development plans.

This study also points to areas for future research, such as exploration of the differences in decision making between male and female family physicians; the relative importance of different reasons given for continuing or discontinuing the practice of obstetrics; and types of solutions that family physicians would suggest to provide them better support for personal issues, such as parenting young children or early career challenges, for organizational issues, such as limitations on the number of deliveries or workplace climate, and for continuing professional development. It would also be interesting to examine the transferability of the conceptual framework and chronologic pattern evoked here to other clinical settings, such as other Canadian cities, rural areas, or countries with different health care delivery systems.



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Acknowledgment

Funding support was provided by a 2011 Janus Grant from the College of Family Physicians of Canada awarded to **Dr Dove** and by the Fonds de recherche du Québec to support **Dr Rodríguez** as a senior research scholar from 2012 to 2016.

Contributors

Dr Dove conducted the literature review with the assistance of the library of the College of Family Physicians of Canada, developed the interview guideline, contacted potential physicians to participate in the study, listened to all interviews and checked the transcripts for accuracy, coded 6 interviews, participated in the iterative cycle to identify themes and draw conclusions, and assisted with the writing of the final paper. **Dr Dogba** conducted all interviews, coded 6 interviews, participated in the iterative cycle to identify themes and draw conclusions, and wrote the final paper and ensured it was consistent with submission guidelines. **Dr Rodríguez** guided the first author in the literature review and in the development of the methodology and the interview guidelines, participated in the iterative cycle to identify themes and draw conclusions, and assisted with the writing of the final paper.

Competing interests

None declared

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