The obstetric care crisis facing Ontario's rural hospitals

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Résumé : Utilisant l'exemple du service d'obstétrique d'un petit hôpital communautaire, l'auteur traite de la diminution abrupte des services médicaux offerts par les hôpitaux communautaires de l'Ontario. Une enquête chez les patientes a démontré que les femmes veulent accoucher dans leur ville. Une enquête chez les médecins a révélé un refus uniforme de pratiquer l'obstétrique sans l'appui d'un anesthésiste et d'un chirurgien de relève. L'article examine aussi l'incidence des sages-femmes, mais il conclut que sans un appui approprié, les sages-femmes n'apporteront pas une solution aux problèmes qui se posent dans les hôpitaux communautaires en milieu rural pour la prestation des soins obstétricaux.

Obstetric services in small community hospitals in Ontario are facing increasing pressure because there is a shortage of primary care personnel and staff with the skills needed to respond to emergencies. In 1987, the Task Force on the Implementation of Midwifery in Ontario recognized that interest in that type of care was growing and concluded that implementation of care by midwives would increase the birthing choices available to women.

With these two trends in motion, will obstetric care in small community hospitals survive, will it be enhanced, or will the overall standard deteriorate? The experiences at my small community hospital in rural Ontario may provide some answers.

The Alexandra Marine and General Hospital (AMGH), with 50 active-treatment beds, is located in Goderich, about 100 km northwest of London. With a population of approximately 7500 people, Goderich is considered to be "rural" — that term applies to any community with fewer than 10 000 residents. About 85% of Ontario is considered rural, although these small communities account for only 25% of the province's population.

In 1992 there were 117 births at AMGH, which is roughly the annual average over the past 10 years, but like many other small community hospitals in Ontario, AMGH is undergoing stressful changes due to the loss of medical services.

The Committee on Reproductive Care of the Ontario Medical Association (OMA) recently completed a document, *Trends in Reproductive Care: A Medical Perspective*, which examines all factors affecting the provision of obstetric care. In their chapter on small community hospital obstetric services, Chance and Stretch[1] cite two studies to demonstrate the rural crisis that has developed because of a shortage of medical services.

Rourke[2-4] surveyed 88 Ontario hospitals with up to 99 acute care beds. Eighty, which accounted for about 10 600 births annually, responded. Most of the hospitals relied upon family physicians to handle deliveries; 45 of the hospitals had fewer than 50 active beds and 35 had between 50 and 99 active beds. The hospitals with fewer than 50 beds served, on average, 10 500 people.

Thirty-four percent of the hospitals reported a shortage of family physicians who provided obstetric care and 66% predicted a shortage within 5 years; 36% reported an ongoing shortage of anesthetists, while 49% predicted a shortage within 5 years. Thirty percent were coping with a shortage of general surgeons, and 61% predicted a shortage within 5 years.

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Cesarean section was available at 53 (66%) of the hospitals surveyed. It was available at all times at 21 hospitals (26%), and most of the time at 32 hospitals (40%), but 14 (30%) were without any general surgery services.

A second study, by Chance and Campbell,[5] involved a survey of 100 acute care hospitals that had 750 or fewer births annually; 86 responded. Six of the 14 that did not respond had already discontinued obstetrics or were in the process of doing so. Four others had discontinued obstetrics during the year of the survey, and six more anticipated a discontinuation within 2 years because of the loss of GP obstetricians.

The survey indicated that there was a shortage of physicians able to perform cesarean sections. Eleven of 25 hospitals with fewer than 100 births annually had no anesthetic service. Of 209 GP anesthetists, 23 at 15 hospitals anticipated ceasing their anesthetic practice within 2 years of the survey. Of the hospitals with under 100 annual deliveries, 15 did not have the surgical capacity to provide a cesarean section; among the 31 hospitals reporting 100 to 249 births annually, four lacked that capability. Those that could not perform cesarean sections were, on average, 178 km from the nearest surgical facility; the closest was 58 km away.

A 1987 Ontario-wide study by Bain et al[6] focused on the reasons why physicians end or consider ending their obstetric work. Forty-two percent of respondents indicated that interference with personal and family life was the main reason.

Historically, family physicians who practise obstetrics in rural settings have provided excellent care. In his 1988 survey of small hospitals with fewer than 100 deliveries per year, Hogg[7] showed that through careful selection of patients, neonatal mortality rates are comparable to level 2 and level 3 hospitals. In a 1984 study, Black[8] surveyed obstetric services in small communities in Northern Ontario and determined that perinatal mortality rates were comparable with those of level 2 hospitals. Both studies reflected careful selection and referral of women with an identifiable risk of complications around the time of birth.

Despite these encouraging results, physicians remain anxious and feel vulnerable. A 1980 study by Wilson and Schifrin[9] suggested that approximately 15% of women experience complications during pregnancy and birth, 5% of which are serious.

At AMGH, a comparison of anesthesia and general surgery services between 1987 and 1992 provided these results:

- In 1987, three GP anesthetists provided continuous coverage. In June 1992, one gave up his anesthesia privileges because of lifestyle pressures. One of the remaining anesthetists has since considered giving up his privileges because of the added work load. Continuous anesthesia coverage is no longer available.
- In 1987, there were two general surgeons living and practising in the town, and they provided almost continuous coverage. The older doctor, in his early 60s, informed the hospital board in September 1989 of his intention to retire in 1 year. Since then the hospital has conducted an exhaustive search for a suitable replacement, without success. [In September the search finally paid off. — Ed.] The remaining general surgeon, now nearing age 60, finds it impossible to provide coverage more than 65% of the time. In his absence, the community attempts to call upon other doctors — two general surgeons living 30 to 40 minutes away and an FP in a neighbouring town who is trained to perform cesarean sections. [The FP has since relocated to the US. — Ed.] The availability of the two remaining doctors may depend on driving conditions.
- Analysis of all hospital-initiated transfers of women in labour between 1987 and 1991 showed that before 1990 there was an average of 13 transfers annually, all for risk factors that could be handled better at a level 3 hospital. In 1990 there were 17 transfers, including 4 because of lack of surgical coverage and 1 because an anesthetist wasn't available. In 1991, 5 of the 21 transfers were caused by a lack of surgical coverage, including 2 for which anesthesia coverage was also lacking. Figures are not available for transfers from doctors' offices.

The loss of medical services has had a profound effect on my hospital and its staff. Local residents are also aware of the problem and the availability of surgical and anesthesia coverage has become a major concern of expectant mothers and their families. The physicians feel particularly vulnerable when on call on a weekend during which coverage may not be available. They are

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reluctant to become involved even in births with no identifiable risks because they know that the resources needed to deal with unexpected complications may be 90 minutes away.

It is now the practice to transfer all women safe to travel to a referral hospital. This causes anxiety for both expectant mothers and their families, as well as for the physicians and nursing staff. It is also unfortunate for the referral centre, which has to provide care for women who could receive adequate care in an appropriately staffed level 1 facility.

To discover the impact on patients, a questionnaire was distributed by mail to 153 women aged between 18 and 35. Recipients included those who had given birth in the obstetric unit in the past year, members of a young women's group at a local church, members of a local chapter of Women Today, and those who participated in public health prenatal classes.

Eight-seven percent of respondents felt it was important or very important to give birth in their hometown. Thirty-one surveys were returned with comments; 20 pertained to the quality of family-centred care at AMGH, 19 of which were very positive. There were seven comments from respondents who had given birth at both a city hospital (in Toronto, London or Hamilton) and the local hospital. In all instances, they extolled the personal care they received in Goderich and provided unequivocal support for giving birth in their hometown.

While 33% of respondents expressed an interest in giving birth with the assistance of a midwife, less than 5% perceived the midwife as the primary caregiver. The comments indicated that this latter group consider home birth their preferred choice.

In September 1992, a questionnaire that had been sent to family physicians involved with obstetrics at the AMGH in 1987 was recirculated. It was designed to estimate the importance of factors that influence the practice of obstetrics in a small community hospital.

The 1992 survey also included a three-part question regarding the implementation of midwifery in Ontario, and physicians were asked how comfortable they felt about maintaining their obstetric skills with their present caseload. The birth statistics for each physician practising during both study periods were compared to note any trends, such as increased or decreased caseloads.

In 1987, seven local FPs were practising obstetrics. By 1992 two of them had stopped doing this work but another physician had arrived and was included in the 1992 survey.

In 1987, three of the seven respondents were aged 30 to 34, three were aged 40 to 44, and one was older than 50. Of the six physicians surveyed in 1992, four were aged 35 to 39 and the other two were aged 45 to 49.

The data suggest that physicians aged 30 to 34 are at the peak of their obstetric practice and on the whole the families they serve are younger. Families in a practice tend to parallel the age of the attending physician, so after age 45 the number of births attended falls. By age 50, physicians are either deciding or have already decided to stop delivering babies; they cite sharply decreasing numbers of patients, a decreased comfort level, increased effects on lifestyle, increased anxiety regarding litigation, and the perceived disincentive of malpractice insurance premiums.

Without an influx of physicians trained and willing to include obstetrics in their practice, it appears that Goderich will lose more GP obstetricians over the next 5 years. If physicians continue to be the primary caregivers for birthing mothers, then fewer physicians will be attending more births. Each of the busier physicians already reported that the increased caseload has had a major impact on lifestyle. They will likely become less satisfied if caseloads continue to grow.

This survey indicated some scepticism concerning the implementation of midwifery in small communities. All physicians felt the presence of a midwife as a labour coach would be either unimportant or a neutral factor. Most felt the midwife would not make an acceptable birth attendant. None felt that having midwives attending births would be a factor in their decision to discontinue obstetrics.

The physicians were uniformly uncomfortable practising obstetrics in their community hospital in the absence of anesthetic or surgical coverage. For several doctors, this absence would be the determining factor in their decision to give up obstetrics. Others would attend only emergency births and would make arrangements for all others

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to go to the nearest referral centre.

The analysis of anesthesia and surgical services parallels perfectly the findings and warnings contained in the studies mentioned earlier. It is conceivable that within 5 years this community hospital may be without any general surgical services and may have lost one or both of its GP anesthetists.

The shortage of staff with the skills needed to respond to inevitable obstetric emergencies is bound to be a serious disincentive for family physicians who had considered including obstetrics in their practices.

Women prefer to give birth in their hometown, and if residents of Ontario's rural communities had their say local obstetrics units would surely survive. But these units are closing because the skilled personnel required are not available.

Family physicians in Goderich express a high level of satisfaction about making obstetrics part of their practice. They doubt that the implementation of midwifery will help them and their patients.

Most women in rural communities consider the family doctor their primary caregiver and the entry point for care needed during a pregnancy. Without the involvement and acceptance of these physicians, midwives will not have sufficient caseloads.

Family physicians see themselves as advocates for safe care for their patients, and are unlikely to cooperate in births under conditions that make them feel apprehensive. I doubt that a physician, having given up delivery privileges because of a lack of back-up obstetric services, would ever refer or encourage patients to seek a midwife's care under similar conditions. On the other hand, if safety is not the reason why physicians are declining to attend births, midwives surely would be a benefit to the community and, in the long run, would be accepted and busy.

There will be an overall deterioration in obstetric care in rural areas if shortages involving anesthesia and general surgery are not addressed soon. The integration of midwives will not help address the basic problem of providing safe care in rural communities.

Solutions must be sought by all concerned. The present trend, in which family physicians are either leaving or refusing to enter obstetric practice, must be reversed. Family practice residents should be exposed to and receive at least some of their obstetric training in rural settings. Advanced training that allows family physicians to perform cesarean sections should be developed for those wishing to practise in areas that cannot attract general surgeons. Likewise, the supply of trained GP anesthetists must be assured.

Government's first responsibility lies in the provision of basic care. Once that basic standard can be assured, then diversification and choice can only serve to enhance care.

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