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The Family Doctor in Obstetrics: Who's Looking after the Shop?

SUMMARY

This article constitutes a report on a survey of 1338 family physicians/general practitioners in Ontario. The survey, which achieved a response rate of 74%, investigated respondents' patterns of obstetrical practice and attitudes towards that practice. The detailed statistics collected show a decline in FP/GP involvement in obstetrical care. Physicians who had never practised obstetrics cited inadequate training and lack of interest as their chief reasons. Physicians who had given up obstetrical practice cited most frequently its interference with personal and family life, interruption of office schedule, rising CMPA fees, and low financial incentives as reasons for their decision. In the youngest group of respondents, no significant differences were found between males' and females' rates of choice to practise or not to practise obstetrics. Respondents who had never practised obstetrics were likely to live in larger communities, and those practising obstetrics to live in smaller communities. Various changes in patterns of practice were identified by some respondents subsequent to their giving up obstetrics. A large majority of this group expressed satisfaction with those changes. Over half the respondents stated that they would accept well-trained midwives practising under supervision in a hospital setting. A strong majority of respondents favoured the concept of family physicians with a special interest in obstetrics taking over, either alone or in association with obstetricians and/or midwives, the obstetrical cases declined by their colleagues. (*Can Fam Physician* 1987; 33:2693–2701.)

RÉSUMÉ

Cet article constitue le rapport d'une enquête effectuée auprès de 1 338 médecins de famille/praticiens généraux ontariens. Cette enquête, dont le taux de réponses est de 74%, a voulu investiguer les modes de pratique obstétricale des répondants et leurs attitudes face à cette pratique. Le détail des statistiques colligées montre un déclin de l'implication des MF/omnipraticiens dans le domaine des soins obstétricaux. Les médecins qui ne font que peu ou pas d'obstétrique mentionnent que les raisons principales en sont l'insuffisance de formation et le manque d'intérêt. Quant aux médecins qui ont abandonné la pratique obstétricale, les raisons les plus fréquemment invoquées sont l'interférence avec la vie personnelle et familiale, l'interruption dans les horaires de bureau, l'augmentation du coût des primes de l'Association canadienne de protection médicale et le peu d'incitatifs financiers. Parmi le plus jeune groupe de répondants, on n'a constaté aucune différence significative entre les hommes et les femmes quant au choix de pratiquer ou non l'obstétrique. Les répondants qui n'avaient jamais ou rarement pratiqué l'obstétrique étaient plus susceptibles de vivre dans de grandes villes alors que ceux qui pratiquent l'obstétrique vivent dans des communautés moins populeuses. Certains répondants ont identifié divers changements dans leur mode de pratique suite à l'abandon de l'obstétrique. La grande majorité de ce groupe s'est dite satisfaite de ces changements. Plus de 50% des répondants ont mentionné leur accord à ce que des sages-femmes bien formées pratiquent sous supervision dans un contexte hospitalier. Par ailleurs, une forte majorité des répondants favorise le concept de l'implication de médecins de famille particulièrement intéressés, soit en pratique solo, soit en association avec les obstétriciens et/ou les sages-femmes, à prendre la relève de leurs confrères qui abandonnent cette pratique.

Key words: obstetrics, family physicians, general practitioners

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THE DECLINING involvement in obstetrical care by Ontario's family physicians represents a challenge to those responsible for health-care planning and for teaching Family Medicine. The Ontario Chapter with the College of Family Physicians of Canada sponsored a study to determine the extent to which involvement in obstetrics had declined, to discover the major reasons for this trend, and to determine whether their findings would suggest any action that might encourage family physicians to continue to practise obstetrical care.

Klein and his colleagues[1] have noted that the decreasing participation of family physicians in obstetrical care, evident mainly in Quebec and Ontario, seemed to be related to the ratio of obstetricians to the population. While family physicians are distributed throughout larger and smaller communities in Canada, obstetricians are concentrated in the larger centres. Consequently, family physicians based in smaller communities are more likely to practise obstetrics than are physicians in larger urban centres.

In 1982, the Canadian Medical Association determined that 56.5% of Canada's family physicians practised intranatal obstetrics.[2] In 1985, a study conducted in Alberta of family physicians' attitudes towards obstetrics found that 66.7% of the respondents were providing complete obstetrical care, 24.8% no longer practised obstetrics, 8.5% had never practised obstetrics, and 10% were planning to discontinue obstetrical practice within the following two years.[3]

Cutner and Peters[4] have reported on the effect of quality of training on the continued interest shown by Family-Practice residents in the United States in practising obstetrics throughout their three-year training programs. Residents who retained an interest in obstetrics were more likely to have trained in programs that followed most closely the guidelines of the American Academy of Family Physicians (AAFP). These guidelines promote a joint Family Practice-Obstetrical Training Committee, a minimum of three months of obstetrical training, an additional three months of training for residents planning to include obstetrics in their practice, and additional intensified experience for trainees intending to practise in areas where specialist services are not readily available. Canadian authors, too,[5-7] have emphasized the importance of the obstetrical component of Residency Training in Family Medicine.

Method

Our survey team sent questionnaires to 1802 randomly selected general practitioners/family physicians (both members and non-members of CFPC) of the nearly 8000 GP/FPs in the province of Ontario. After follow-up mailings, 1338 responses were received, representing a response rate of over 74%. Respondents were asked to record their year of birth, sex, location of medical school, CFPC Certification, current type of practice, community size, hospital affiliation, details of training, and assessment of their own post-training competence in performing various basic obstetrical procedures. Those family physicians who provided little or no obstetrical care were asked to record the reasons. Those who had provided obstetrical care at any time were asked to state the number of years during which they had done so, to estimate the maximum number of births they had attended in any given year, and to record details of their practice. If they were currently providing obstetrical care, they were also asked if they had ever considered stopping. Those who had stopped were asked about resulting changes in their practice pattern and patient satisfaction. The reasons for discontinuing or considering discontinuing obstetrical practice were recorded, and those who had discontinued or never undertaken the practice of obstetrics were asked for information about their referral patterns. All respondents were asked about their attitudes towards the role of midwives.

Table 1
Sex

	Male	Female
Total respondents (n=1338)	80%	20%
CFPC Members (n=727)	77%	23%
Non-members (n=611)	83%	17%
Residency-trained (n=451)	71%	29%

Table 2
Medical School

	Canada	U.K.	Elsewhere	NA
Total respondents (n=1338)	77%	11%	11%	1%
CFPC Members (n=727)	87%	6%	7%	
Non-members (n=611)	66%	18%	16%	
Family Medicine Residency Trained (n=451)	90%	3%	7%	

Results

The data obtained from all respondents were analysed as a whole and were also broken down by various subgroups of respondents as appropriate for each question. These subgroups included CFPC members and non-members, rotating interns, and family medicine-residency trained respondents. In an attempt to gauge the future involvement of family physicians in obstetrical practice, we also identified a core group consisting of those respondents born in 1946 or later. Members of this group would now be 40 years of age or younger, and most of them are likely to be in practice for the next 25 years. This group numbered 653 and thus represented approximately one-half of all of the respondents. For some analyses we further subdivided from this group

those respondents born after 1954 (n=177).

Demographics

Of the survey's overall sample, 20% was female (Table 1). This figure is comparable to the percentages obtained in other studies and to the 24% female membership in the Ontario Chapter-CFPC. Twenty-three per cent of the CFPC members and 17% of the non-members were female. The larger percentage (29%) of female physicians in the group of residency-trained physicians reflects the increasing numbers of females entering Family Medicine Residency Programs.

Overall, 77% of the respondents were graduates of Canadian medical schools, as were 87% of the CFPC-member respondents, 66% of the non-member respondents, and 90% of the Family Medicine Residency-trained respondents (Table 2). The single largest group of graduates from non-Canadian schools, 11% overall, were graduates of United Kingdom medical schools.

Type of practice and community size

Forty-five per cent of all of the respondents are practising in communities with a population over 100 000, and 17% in areas with a population of fewer than 10 000 (Table 3). Forty-five per cent of respondents are associated with hospitals containing more than 300 beds, while 33% are associated with hospitals containing 100–300 beds.

Training

Considerable overlap occurred in answers to questions relating to training. For example, it is possible to graduate from a Family Medicine program following a rotating internship or some other type of training during the first year. Five hundred and sixty-seven (42%) of the respondents had completed a rotating internship, while 451 (34%) had taken a Family Medicine Residency program. The remainder had taken mixed training. Among Family Medicine Residency-trained respondents, 51% estimated that they had attended 50 or more births, as did 40% of those trained in rotating internships. Forty-six per cent of the Family Medicine Residency-trained respondents had received more than two months of obstetrical training, while only 27% of those taking a rotating internship had done so.

Adequate for needs

Of those respondents trained in rotating interships, 70% believed that their training adequately met their needs on entering practice. Of the Family Medicine Residency-trained respondents, 67% considered that their training had been adequate.

Table 4 records the percentages of respondents who felt confident in undertaking various basic obstetrical procedures after the completion of their training. Those who had taken additional obstetrical training expressed a greater degree of confidence in undertaking these procedures.

Eighty-five per cent of all respon-

Table 3
Community Size

	Population				
	Less than 10,000	10,001–50,000	50,001–100,000	100,001–500,000	More than 500,000
Total respondents (n=1338)	17%	22%	14%	28%	17%
CFPC Members (n=727)	15%	17%	14%	33%	18%
Non-members (n=611)	20%	27%	13%	22%	15%
Residency-trained (n=451)	14%	17%	15%	35%	17%

	Size of Hospital				
	1–50 Beds	51–100 Beds	101–300 Beds	301+ Beds	No hospital Affiliation
Total respondents (n=1338)	4%	11%	33%	45%	4%
CFPC Members (n=727)	4%	9%	32%	50%	3%
Non-members (n=611)	5%	13%	35%	40%	6%
Residency-trained (n=451)	3%	10%	34%	49%	3%

Table 4
Respondents' Confidence in Undertaking Obstetrical Procedures After Training

	After Completion of Internship (n=1081)	After Completion of FM Residency (n=451)	After Completion of Additional OB Training (n=147)
Spontaneous vaginal delivery	90%	90%	98%
Low forceps delivery	69%	67%	93%
Induction of labour	53%	55%	81%
Management of postpartum hemorrhage	59%	63%	82%
Fetal monitoring[a]	32%[a]	51%[a]	47%[a]
Manual removal of placenta	53%	43%	81%
Caesarean section	6%	6%	34%

a. Misleading, as many indicated that this procedure was not available at the time of their training.

dents believed that total obstetrical care should be a compulsory part of the postgraduate training of family physicians/general practitioners. Seventy-nine per cent of the physicians who had practised little or no obstetrics ever, 87% of those who used to practise obstetrics but have now stopped, 88% of those who still practise obstetrics but have considered stopping, and 94% of those who practice obstetrics and have not considered stopping hold the same view.

Number of family physicians practicing obstetrics

We found that 29% of all of our respondents had never practised obstetrics (Figure 1). (It should be noted that this category includes physicians who practised obstetrics briefly, early in their career, and then stopped doing so.) Of this group, however, 53% do provide prenatal care to some or all of their patients. An additional 28% of the respondents had practised obstetrics, but have now ceased to attend births. However, 48% of this group still provide prenatal care to some or all of their patients. Five hundred and twenty-one (40%) of all respondents currently practise obstetrics, but 59% of this group have considered stopping.

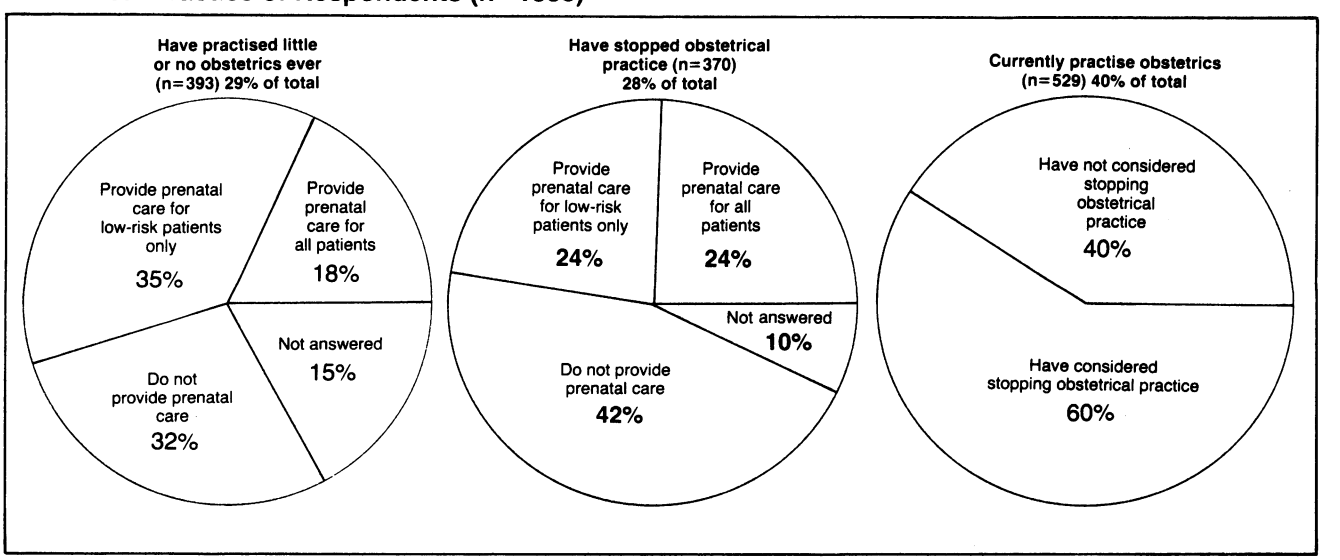
Some physicians have suggested that anyone who has ever practised obstetrics has, at least at some point, considered stopping. In our questionnaire, those respondents who stated that they had considered giving up obstetrical practice were channelled into a series of questions exploring their reasons. In selecting this response, a respondent was publicly, (albeit anonymously), stating that he or she had considered this option seriously enough to answer the questions concerning their reasons. Those who had not considered this option with serious intent were directed to other questions.

As a result, the data showed that only 16% of all of our respondents have been practising obstetrics and have not considered stopping. Thirty-seven per cent of the Family Medicine Residency-trained respondents have never practised obstetrics, 20% have discontinued the practice of obstetrics, 25% practise obstetrics but have considered stopping, and 18% practise obstetrics and have never considered stopping. Of all of the respondents who have practised obstetrics at any time and have stopped, approximately 75% have done so since 1975. Our respondents' reasons for discontinuing obstetrical practice are found in Tables 5 & 6. Interference with personal and family life is the leading cause in both "main cause" and "contributing cause" categories. This appears to be a more significant reason for the younger family physicians. The 29% of respondents who have never practised obstetrics provided a different set of reasons, chief of which was inadequate training (Table 7).

The respondents' choices concerning obstetrical practice are related to the population figures of the communities in which the respondents practise. Significantly greater numbers (57%) of those who have never practised obstetrics live in communities with a population of over 100 000 persons (Table 8). In comparison, 48% of those respondents who have discontinued the practice of obstetrics live in communities of this size, as do 32% of those who practise obstetrics and have considered stopping, and 35% of those who practise obstetrics and have not thought of stopping. Conversely, proportionately greater numbers (28%) of respondents who practise obstetrics and have not considered stopping live in communities with a population of less than 10 000, as do 23% of those who practise obstetrics and have considered stopping, 12% of those who have discontinued the practice of obstetrics, and 13% of the respondents who have never practised obstetrics.

When male and female physicians' patterns of obstetrical practice were compared, some significant differences were found. Data for the various age categories of male and female practitioners were analysed separately (Tables 9 and 10). Significantly more of the females than of the males in the age group of respondents born before 1946 were likely never to have practised obstetrics during their careers. Again, of the respondents born between 1946 and 1954, significantly more females than males had seldom or never practised obstetrics. Among the youngest respondents (those born after 1954) there were no significant

Figure 1
Obstetrical Practice of Respondents (n=1338)



differences between males and females in relation to choices concerning obstetrical practice.

Female family physicians, as a group, have increased in number in proportion to male family physicians, but their patterns of obstetrical practice have not changed a great deal. Female respondents born before 1946 were as likely as those born after 1954 never to have practised. Of those female physicians practising obstetrics, significantly fewer of the youngest respondents (those born after 1954) had given up this part of their practice, and more of them were practising obstetrics without considering stopping.

Significantly more of the youngest males (those born after 1954) have never practised obstetrics. The older male respondents (those born before 1946) were significantly more likely to have practised obstetrics and now have ceased to do so. The youngest male respondents (those born after 1954) were also significantly more likely than the older respondents to be practising obstetrics without considering stopping.

Table 5
Reasons for Discontinuing or Considering Discontinuing Obstetrical Practice

	A	B	C	D	E
1. Interference with personal and family life	42%	69%	87%	73%	90%
2. Interruption of office schedule	30%	51%	56%	44%	54%
3. Increasing CMPA fees	28%	37%	37%	62%	65%
4. Low financial incentive	26%	35%	39%	59%	64%
5. Fee didn't compensate for lost office time	24%	36%	39%	47%	54%
6. Insufficient number of deliveries	22%	39%	37%	30%	34%
7. Fear of litigation	17%	19%	25%	41%	47%
8. Unrealistic patient expectations	10%	14%	19%	18%	16%
9. Inadequate training	10%	13%	22%	12%	22%
10. Hassles with labour-room nurses	7%	13%	17%	8%	7%
11. Not satisfied with own performance	6%	12%	14%	7%	10%
12. Hassles with obstetricians	5%	9%	11%	6%	7%
13. Other (personal reasons)	10%	24%	17%	8%	4%

A = all respondents who ever practised obstetrics (n=902)
B = all respondents who have discontinued obstetrical practice (n=370)
C = all respondents born in 1946 or later who have discontinued obstetrical practice (n=127)
D = all respondents who practise obstetrics, but have considered stopping (n=305)
E = all respondents born in 1946 or later who practise obstetrics, but have considered stopping (n=147)

Table 6
Main Reason Given for Discontinuing the Practice of Obstetrics

	A	B	C	D	E
1. Interference with lifestyle	24%	26%	39%	29%	41%
2. Other (personal reasons)	9%	15%	6%	4%	4%
3. Insufficient number of deliveries	8%	9%	11%	7%	7%
4. Increased CMPA fees	6%	4%	1%	10%	6%
5. Low financial incentive	4%	3%	2%	8%	8%
6. Interruption of office schedule	2%	4%	3%	1%	1%
7. Unrealistic patient expectations	2%	3%	2%	2%	1%
8. Inadequate training	3%	2%	2%	2%	3%
9. Fear of litigation	3%	2%	7%	4%	6%
10. No main reason	16%	20%	20%	15%	18%

A = all respondents who ever practised obstetrics (n=902)
B = all respondents who have ceased to practise obstetrics (n=370)
C = all respondents born in 1946 or later who have ceased to practise obstetrics (n=127)
D = all respondents who practise obstetrics, but have considered ceasing to do so (n=305)
E = all respondents born in 1946 or later who practise obstetrics, but have considered ceasing to do so (n=147)

On-call arrangements

Seventy-two per cent of those respondents practising obstetrics have on-call arrangements, and of these, 84% have arrangements with another family physician and 14% with an obstetrician. Eighty-one per cent of respondents take their own obstetrical calls even at times when their practice is signed out to a colleague. Respondents who have ceased to practise obstetrics refer 50% of their patients to obstetricians, 10% to family physicians, and 22% to both. (Eighteen per cent of the physicians in this category did not respond to this question.) Those physicians surveyed who had never practised obstetrics refer 51% of their pregnant patients to obstetricians, 7% to family physicians, and 12% to both. (Thirty per cent did not respond to this question.) Respondents choosing not to refer obstetrical patients to another family physician base their choice on the following: patient re-

Table 7
Respondents Who Have Practised Little or No Obstetrics:

Reasons for Ceasing	A	B	C
Inadequate training	36%	40%	40%
Never been of interest	32%	26%	21%
Lifestyle	15%	20%	23%
Distance from hospital	4%	3%	4%
Practising emergency medicine	6%	9%	9%
Inadequate volume	4%	4%	6%
Currently doing locums	5%	5%	5%

A = all respondents (n=393)
B = respondents born in 1946 or later (n=242)
C = Family Medicine Residency trained (n=166)

quests (21%); few family-physician colleagues practise obstetrics (11%); no family-physician colleagues practice obstetrics (6%); desire to refer to the best-qualified physicians (10%); convenience (2%); unwillingness of other family physicians to accept extra obstetrical cases (4%); and other assorted personal reasons (12%).

Overall changes in practice since giving up obstetrics

Approximately 43% of the respondents who have ceased to practise obstetrics have noted no change in their practice pattern in relation to the number of children seen or to the proportion of office- or hospital-based work they do (Table 11). Forty-three per cent of the respondents see fewer children, 42% indicated that their practices are now more highly office-based, and 39% said that their practices are now less hospital-based. Eighty-eight per cent of the respondents reporting changes in their practice patterns stated that they were satisfied with these changes, and 79% of these respondents reported that their patients were satisfied with the changes. The remaining 12% of this group were personally dissatisfied with the changes, and 21% reported that their patients were dissatisfied as well.

Role of midwives

The response to the question, "If an increasing number of Family Physicians stop obstetrical deliveries, who should do them?" is shown in Figure 2. There is a strong feeling (72%) that a selected group of family physicians/general practitioners with a special interest in obstetrics should attend these deliveries, either alone (28%), in association with an obstetrician (23%), with a well-trained midwife (6%), or with all three (15%). Although only a small number of respondents (6%) believed that well-trained midwives alone should perform this service, the response to the question, "Would you be willing to accept well-trained midwives performing low-risk deliveries in hospital with supervision?" was answered affirmatively by 53% of the respondents. Significantly more female physicians, CFPC Certificants, graduates of U.K. medical schools, and physicians from larger communities and larger hospitals replied affirmatively to this question. Questions concerning other models of midwifery care were not included in this survey, and therefore these responses should be considered as only preliminary. Further research would be required to determine the most suitable/acceptable models of midwifery from the perspective of family physicians/general practitioners.

Discussion/Future Projections

Of all of the respondents practising obstetrics at any time who later discontinued this part of their practice, approximately 75% had ceased to practise obstetrics since 1975. This finding raised the question: "What has occurred during the past 12 years to change dramatically the pattern of obstetrical practice of family physicians in Ontario?"

Our study results point us in a number of directions. They indicate that respondents practising obstetrics were likely to be living in Ontario's smaller communities, and those not practising obstetrics were likely to be living in the province's larger communities. The observation relating obstetrical practice choices to community size supports that of Klein and his colleagues,[1] who found that in larger communities, where numerous obstetricans are available, family physicians are less likely to practise obstetrics.

By subdividing the data according to the age-defined subgroups that we described earlier, a progressive increase was seen in the proportion of family physicians who have seldom or never practised obstetrics: 30% of the total group of respondents belonged to this category, 36% of those born after 1946, and 46% of those born after 1954.

On detailed examination of these differences in practice patterns among the age groups, when considered by sex, the data showed that the increased percentage of the youngest physicians choosing not to practise obstetrics resulted both from the larger numbers of male physicians choosing not to practise obstetrics, and from the higher percentage of female physicians in this age category. Among female family physicians, regardless of age, the proportion (approximately 50%) of those choosing not to practise obstetrics has remained more or less the same. The younger male physicians are now approaching the same rate (46% according to our data) of choosing not to practise obstetrics. Those who ceased to practise obstetrics were significantly more likely to be the older male respondents.

Our study data for the youngest group of respondents is limited, but it now appears that the current proportion of female-to-male residents in family medicine programs is nearly equal, and that the youngest physicians of both sexes in equal proportions, have chosen *not* to practice obstetrics.

Our study team examined in detail the respondents' reasons for not practising obstetrics. Tables 5, 6, and 7 summarize the reasons stated by various subgroups of respondents for

Table 8
Choice of Obstetrical Practice by Population of Community

	Less than 10,000	10,001–50,000	50,001–100,000	100,001–500,000	500,001 or more	NA
All respondents who have never practised obstetrics (n=393)	13%	16%	11%	33%	24%	3%
All respondents who have discontinued OB practice (n=390)	12%	20%	18%	26%	22%	2%
All respondents who practise OB but have considered stopping (n=305)	23%	30%	13%	24%	8%	2%
All respondents who practise OB and have not considered stopping (n=227)	28%	26%	10%	28%	7%	0%

never having practised obstetrics, or for ceasing to do so, or for considering giving up the practice of obstetrics. One of the primary reasons given by all of the above-mentioned groups is the interference obstetrical practice causes with their lifestyle and family life. They next cited financial losses, in terms both of office time and of CMPA fees.

A number of respondents said that the chief reason for their initial lack of involvement in obstetrical care was their belief that they had been inadequately trained in obstetrics. In addition, a number of respondents had chosen to spend extra time taking obstetrical training. This latter group showed the highest degree of confidence in undertaking various basic obstetrical procedures on starting practice. A recent report, produced by the Society of Obstetricians and Gynecologists of Canada in collaboration with the College of Family Physicians of Canada, recommended a longer period of training than most family physicians/general practitioners have undertaken to date. Such an extension of training time might tend to increase the numbers of graduates of Family Medicine Residency Programs who choose to do obstetrics, although it might not have much effect on those who have never been interested in this area of family practice. In addition, a small number of respondents who had discontinued obstetrical practice stated that their reason for doing so was that they considered themselves inadequately trained or were dissatisfied with their performance.

The retrospective nature of our study may have influenced the respondents' responses to some questions, such as the perceived adequacy of their training on starting medical practice. One's memory of the reasons underlying a decision made 10 to 15 years ago can be affected by all that has occurred since. The family physician who chose not to practise obstetrics may remember inadequate training as a prime reason for the choice. A colleague who trained in the same program might initially have felt the same sense of inadequacy, but might have gained competence through experience and the support of fellow practitioners and consultants.

According to Klein and his colleagues,[1] some training environments may adversely affect the trainees'

Table 9
Choice of Obstetrical Practice by Age Subgroup

	A	B	C	D
All respondents born before 1946 (n=620)	22% 69% male 31% female	40% 92% male 8% female	23% 92% male 8% female	15% 85% male 15% female
All respondents born between 1946 and 1954 (n=476)	36% 66% male 34% female	22% 76% male 24% female	25% 83% male 17% female	17% 84% male 16% female
All respondents born after 1954 (n=171)	49% 61% male 39% female	6% 80% male 20% female	20% 71% male 29% female	25% 67% male 33% female

A = all respondents who have never practised obstetrics (n=393)
B = all respondents who used to practice obstetrics but have now stopped (n=370)
C = all respondents who currently practice obstetrics, but have considered stopping (n=305)
D = all respondents who currently practice obstetrics, and have not thought about stopping (n=227)

Table 10
Choice of Obstetrical Practice by Sex and Age Subgroup

		A	B	C	D
Male respondents born before 1946 (n=534)	p<.001	17%	43%	25%	15%
Female respondents born before 1946 (n=86)		49%	22%	13%	16%
Male respondents born between 1946 and 1954 (n=360)	p<.01	31%	22%	28%	18%
Female respondents born between 1946 and 1954 (n=116)		50%	22%	17%	11%
Male respondents born after 1954 (n=112)	not significant	46%	7%	22%	25%
Female respondents born after 1954 (n=59)		56%	3%	17%	24%

A = all respondents who never practised obstetrics (n=393)
B = all respondents who used to practice obstetrics but have now stopped (n=370)
C = all respondents who currently practice obstetrics, but have considered stopping (n=305)
D = all respondents who currently practice obstetrics and have not thought about stopping (n=227)

choice to include or not include obstetrics in their practice. Family practice residency training in a tertiary-care centre oriented to high-risk care may create the impression that obstetrics is a risky business best left to others. On the other hand, exposure to family practice role models who incorporate obstetrics into a busy family practice in a community-hospital setting would place the trainee in an environment where elective monitoring and episiotomy rates are low, and an expectant approach is taken to the conduct of normal labour. The creation of a section of Family Practice Obstetrics in a teaching hospital might not only facilitate appropriate training in family-centered in-hospital maternal care, but might also promote and maintain optimal obstetrical skills through continuing medical education and audit of patient care.[1] Training in family practice obstetrics should ensure the acquisition of the level of skill and confidence required to identify the high-risk patient; it should also enable the family physician to provide the unique continuity of care required for the woman and her family who seek a natural, less technical delivery.

The study date showed that 81% of family physicians take their own obstetrical calls, even though their practice is otherwise signed out. This finding is not surprising, given the bond that develops between the attending physician and the obstetrical patient during family and prenatal care. Encouraging on-call arrangements with colleagues and peers might allow many family physicians to spend uninterrupted time with their own families and even reduce the "interuption of lifestyle" that is given as a reason for discontinuing obstetrical practice.

Indeed, urgent attention must be given to the problem of how to reduce the interference of obstetrical practice with the physician's lifestyle and family life, as this is becoming a major reason for family physicians to leave the practise of obstetrics. As this reason is mentioned even more frequently by the younger physicians, this problem will not decrease, and is likely only to worsen. Further study of practice management among those family practitioners who have never thought of discontinuing obstetrical practice might determine why there is less interference with lifestyle in their practices and/or provide insight into effective obstetrical practice-management strategies.

Sharing some of the responsibility with a well-trained midwife might prolong the family physician's involvement in obstetrics. While our study showed that most respondents generally supported the role of the well-trained midwife in a hospital setting, it also showed clearly that the midwife was to work "with supervision". As mentioned earlier, other models of midwifery care were not explored and would need to be the subject of further research.

Financial concerns are also among the leading reasons for giving up obstetrical practice. Among the reasons stated were interruption of office schedule, increasing CMPA fees, low financial incentive, and a fee that does not compensate for the loss of office time. All these responses indicate that the financial considerations relating to obstetrical services provided by family physicians must be re-examined. A suitable fee-for-service mechanism will be needed to encourage family physicians to continue to practise obstetrics in Ontario.

When asked who should attend obstetrical deliveries if an increasing number of family physicians/general practitioners cease to practise obstetrics, 72% of respondents stated that a select group of family physicians with a special interest in obstetrics should provide this service, either alone or in co-operation with obstetricians and/or trained midwives. There was quite a discrepancy, however, between what the respondents believed the situation should be and their own practices. When physicians who themselves had given up obstetrical practice were asked to whom they referred their obstetrical patients, 50% stated that they referred their patients to obstetricians; 10% referred their patients to family physicians, and 22% referred them to both. Those who had never practised obstetrics referred only 7% of obstetrical cases to a family physician and 12% to both family physicians and obstetricians. The chief reason cited for non-referral of such patients to a family physician was patient requests (21%). This response may indicate

Table 11

		All Respondents Who Have Stopped Practising Obstetrics (n=370)	All Respondents Born in 1946 or Later Who Have Stopped Practising Obstetrics (n=127)
See infants and children:	More	3%	6%
	Less	43%	24%
	No change	44%	59%
	NA	9%	10%
Office-based practice:	More	42%	39%
	Less	5%	6%
	No change	43%	44%
	NA	10%	12%
Hospital-based practice:	More	4%	4%
	Less	39%	37%
	No change	43%	46%
	NA	14%	13%
		(n=233)	(n=77)
Personally satisfied with reported changes:	Yes	88%	87%
	No	12%	13%
		(n=261)	(n=81)
Patients are satisfied with reported changes:	Yes	79%	77%
	No	21%	23%

public unawareness of the fact that many family physicians still practise obstetrics, and that they could ask for referral to a family physician who practises obstetrics, as it is not necessary to have an obstetrician to deliver a baby! A public-education program might serve to promote family practice obstetrics.

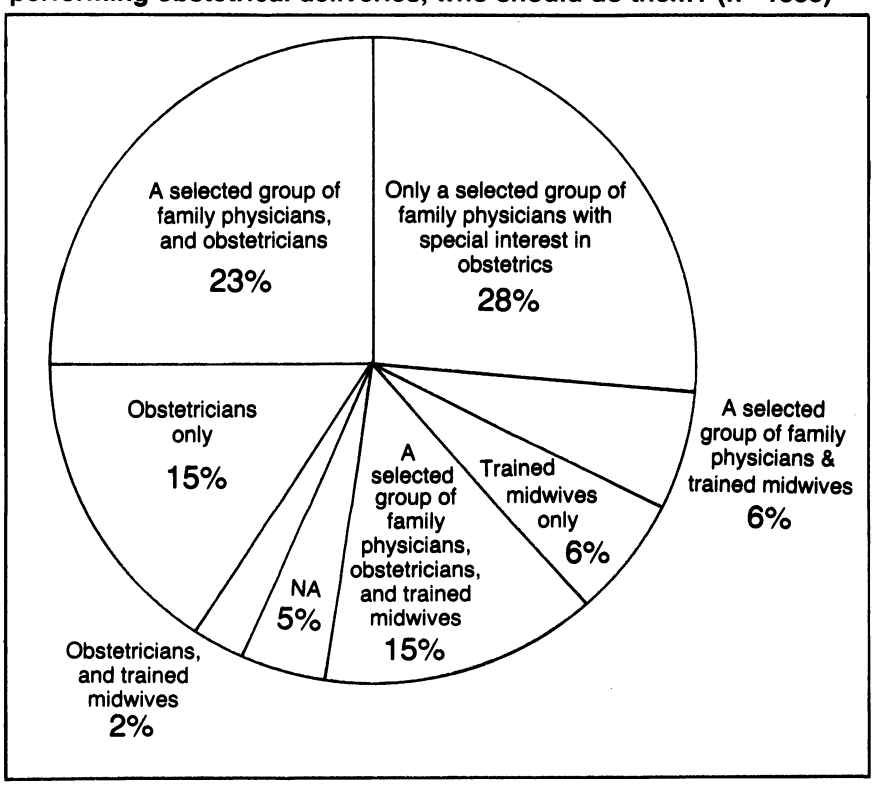
Other reasons often given for non-referral of obstetrical patients to a family physician were that few or no family physician colleagues practise obstetrics (17%), or that family physicians do not want to take on additional obstetrical cases (4%). According to our study data, 40% of our respondents do practise obstetrics, and 7% have even considered stopping because of the low number of deliveries they attend. The situation may depend on the practice setting and on the availability of obstetricians in the area, but it may also stem from a lack of shared knowledge among family physicians concerning who among their colleagues is practising obstetrics and would be willing to take referral patients. In a large city, in particular, where there may be many hundred family physicians—and many obstetricians as well—a central registry of family physicians practising obstetrics might also serve to promote and preserve the place of obstetrical care in family practice.

Conclusions

Our study has identified some salient points relating to the place of obstetrics in family practice in Ontario. We put forward for consideration the following items:

- It must be accepted that not all family physicians wish for various reasons to practise obstetrics. Among the youngest physicians (those born after 1954) approximately 50% have not practised and do not intend to practise obstetrics. The remaining half however, might be encouraged to continue in obstetrical practice or recommence that practice.
- Interference with their lifestyle and family life is a major concern for those who have discontinued or are considering discontinuing obstetrical practice. Encouraging group obstetrical on-call arrangements, as well as sharing some of the responsibility with a well-trained hospital-based midwife, might help to reduce the effect of this concern. Further in-depth study of practice management in family practices where there has been no thought of giving up obstetrical practice might identify additional practice-management strategies in this area. Further research into models of midwifery care should also be conducted.
- Financial concerns are part of a number of reasons given for giving up or considering giving up obstetrical practice. Reimbursement for obstetrical services must be re-examined at the appropriate level in Ontario, and a more suitable payment mechanism must be implemented.
- Existing obstetrical training programs for family physicians should be re-evaluated. Training in family-practice obstetrics should provide the level of skill and confidence required to identify the high-risk patient and to care properly for and deliver the low-risk patient.
- A public-education program might heighten public awareness that family physicians do indeed practise obstetrics, and that low-risk obstetrical patients do not need the care of an obstetrician.
- Registries of family physicians practising obstetrics and willing to take referral patients should be established to assist family physicians who wish to refer their obstetrical patients to other family physicians.

Figure 2
If an increasing number of Family/General Practitioners stop performing obstetrical deliveries, who should do them? (n=1338)



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