

The Accoucheur

A Newsletter for Primary Care in Childbirth

December 2005
Volume 8, Number 4

Farewell to Nova Scotia

It is 11:30 p.m. and I am still at work after just finishing two deliveries. While I am tired, each delivery that I do is now precious because soon I will be leaving Nova Scotia and Canada and probably won't be doing obstetrics for a while, if at all. I received an e-mail from a patient with an attached photograph of five beautiful little girls ranging in age from six years to six months. Not only did I attend all five births, I spent almost every minute of the mother's labour with her. She had severe medical phobia and was never going to have any children. Now, six years and five girls later, she is glowing with happiness. I feel privileged to have witnessed and participated in the transformation of that woman from a panic stricken, angry young woman to a confident, fulfilled young woman at peace with herself. Obstetrics has been a vehicle through which I have witnessed a number of such transformations. It stretches us as patients, families and care providers.

I love obstetrics but have chosen to leave it. Why? I have worked in an academic environment for ten of my



twelve years in practice. It has been my experience that academic family medicine practices claim to support family medicine obstetrics but there is a large gap between what they profess and what they practice. The time I spent engaged in obstetrical activities has largely been at the expense of my other interests of professional development, notably research and further study.

As an academic physician, I had a clinical practice, academic and teaching responsibilities as did many other faculty. However, on top of that were 40 to 50 deliveries per year plus associated hospital newborn and postpartum visits. This does not leave time for much else.

I don't think it is a coincidence that Family Physicians who do obstetrics are underrepresented in the areas of scholarly activity, research, and Family Medicine leadership.

Continued on Page 4

In This Issue

1

- Farewell to Nova Scotia Part One

2

- Midwifery in Nova Scotia
- Pregnancy Care & Residency

3

- Pregnancy Care & Residency Continued

4

- Farewell to Nova Scotia Part Two

4

- Upcoming Events
 - CMNH Event
 - Alarm Courses
- Contact us
- Contribute to the Accoucheur

Midwifery in Nova Scotia

Canadian midwives gathered for their fifth annual conference here in Halifax from the 9th to the 11th of November 2005. During the conference, the Nova Scotian midwives were asked again and again: "So what is the situation for midwives in Nova Scotia?"

In Nova Scotia as well as in the other Atlantic provinces midwifery is still not regulated or integrated into the existing health care system. A small number of midwives are practicing in Nova Scotia; there are none in New Brunswick or PEI. While midwifery practice is not illegal in the Atlantic provinces, the absence of regulation means that midwives can not order any laboratory or diagnostic tests and are unable to directly access pathways of formal consultation or treatment. As a consequence women must be followed concurrently by a physician, to ensure appropriate access to these services.

Midwives are solely financed by their clients. They use sliding scales for their fees that are based on income, in order to accommodate women from a range of financial backgrounds.

In spite of the financial barrier to accessing midwives and the absence of regulation, a growing number of women are turning towards midwives in Nova Scotia. As midwives move towards becoming mainstream providers of maternity care in the provinces where they are regulated and funded (British Columbia, Manitoba, North-West Territories, Ontario, and Quebec), the news about the benefits of midwifery care spreads.

Meanwhile, indicators of a decline in physicians attending births and closures of maternity units in rural areas are creating increasingly stronger motivations to act. The number of family physicians delivering babies in Nova Scotia has dropped from 550 in 1988 to 150 in 2003 and 16 maternity units have also closed across the province since 1988.

The Association of Nova Scotia Midwives (ANSM) in association with the Midwifery Coalition of Nova Scotia (MCNS), the local consumer organization, has been working towards regulation and integration of midwifery in Nova Scotia for two decades. Two provincial government commissions have all recommended regulating and funding midwifery.

More recently, the government has moved forward to form a Midwifery Legislative Committee to draft legislation and as a result midwives and their supporters are once again, cautiously optimistic that Midwifery regulation in this province will become a reality in the foreseeable future.

Maren Dietz RM UK
MCNS <http://mcns.chebucto.org>

InfoPOEMs

Late in utero SSRI exposure may cause neonatal behavioral syndrome

Clinical question

Can late in utero exposure to selective serotonin reuptake inhibitors cause neonatal behavioral abnormalities?

Bottom line

Late third trimester exposure to maternal use of selective serotonin reuptake inhibitors (SSRIs) increases the risk of neonatal behavioral abnormalities. Since the symptoms and signs were relatively benign and short lived, it makes sense to individualize the risks and benefits of continuing SSRI treatment throughout pregnancy. (LOE = 2a-)

Moses-Kolko EL, Bogen D, Perel J, et al. Neonatal signs after late in utero exposure to serotonin reuptake inhibitors. Literature review and implications for clinical applications. JAMA 2005; 293:2372-83.

Vaginal-perianal = vaginal-rectal culture for GBS

Clinical question

Is it necessary to obtain a rectal sample to adequately screen for group B streptococci late in the third trimester of pregnancy?

Bottom line

It is not necessary to put a swab into a woman's rectum to collect a sample to screen for group B streptococci (GBS) in late third trimester pregnancy. Samples from the lower vagina and perianal skin give the same results as samples from the lower vagina and rectum. (LOE = 1b)

Jamie WE, Edwards RK, Duff P. Vaginal-perianal compared with vaginal-rectal cultures of identification of group B streptococci. Obstet Gynecol 2004; 104:1058-61.



Why Pregnancy Care Should be an Essential Part of a Residency Program

I recently read a commentary by Wendy Brooks Barr, entitled *Why Pregnancy Care Should Be an Essential Part of Family Medicine Training*, in the May 2005 *Journal of Family Medicine*. Like Dr. Barr, I am a Family Physician who delivers babies and loves it, however, I do recognize that the obstetrics part of family medicine does not appeal to everyone. Many residents argue that they if do not plan to include obstetrics as a part of their practice, then why should it be included in their residency? I was inspired by Dr. Barr to respond to this question and would challenge residents to think about the myriad of knowledge and skills that this opportunity builds that have an impact on one's practice of medicine far beyond the birth unit. Obstetrics adds so much breadth and depth to my practice by getting me into the OR on a regular basis or by providing a steady flow of newborns for well baby visits. It also gets me suturing regularly, keeps me involved in a manual skill and develops incredible relationships.

I firmly believe in the social accountability of medical schools and especially of family medicine departments to their communities. Obstetrics is facing a crisis; we need more providers and I believe strongly that family physicians provide the best care for low risk pregnancies. As residency programs we have to celebrate this aspect of our expertise and demonstrate clearly why it is such an important part of our discipline. We can be part of the solution by providing family medicine residency graduates who incorporate intrapartum care in their future practice. We must claim ownership of our role so as to better meet the needs of Canadian women as it is our social responsibility to do so.

Research has repeatedly demonstrated our effectiveness in providing the best outcomes in low risk maternity care. I often think we underestimate the skills pregnancy care can facilitate in our residents. This is sometimes the only time I get to directly observe residents complete procedures such as the delivery, basic suturing, rapid decision making, working under pressure, communicating effectively with specialists and an interdisciplinary team, and juggling multiple demands in a single setting. These skills are certainly transferable to other settings and will help lay down a solid clinical foundation on which any resident can tailor a successful future practice, which may or may not include pregnancy care. Obstetrics does not make one's lifestyle unbearable if we learn how to appropriately set limits, transfer patient care responsibly and understand boundaries. This aspect of our life is manageable just like office hours but it does need to be taught so that you stay sane and happy and can enjoy such a rewarding and challenging aspect of family practice.

If residents and programs divest themselves from pregnancy care and especially intrapartum care I would argue that valuable learning opportunities will be lost. Most of us would be alarmed if our residents wanted to exclude common problems from their practice in the future. Barr makes the observation that pregnancy in women is more common than hypertension. At what point are we still family physicians if we whittle away essential components of what has defined us to the present. No hospital care, no pregnancy care, no palliative care, no house calls, no emergency work, no after hours coverage...why not no seniors, or no children, or no one with diabetes?

I can think of only a few areas in medicine that have provided me such a privileged place in a family's life. Continuity in this context is so rich and meaningful and my appreciation has grown over the years as I experience the excitement and privilege of attending women for their second and third births. There is a powerful connection in this aspect of continuity that helps create the very essence of what being a "family" physician is all about. The birthing unit also epitomizes a collaborative care model with multiple providers working together for shared objectives. Our communication skills are challenged and honed in this environment.

Although there is a need for family physicians across the country in a variety of settings, resident's choice will be limited if they do not have obstetrics in their residency training. As many of us have come to realize, life presents many unpredictable changes. Having this obstetrical expertise will definitely improve a resident's future career options. To better prepare for family medicine in general, or for a richer choice of practice options in the future, pregnancy care is an essential component of every resident's education.

Cathy MacLean, MD

Barr, W. (2005) Why pregnancy care should be an essential part of family medicine training. *Family Medicine*, 37(5): 364-6



Continued from page 1

The academic process propagates this inequity by not making appropriate allowances for time and energy that obstetrics requires. In my mind, this reflects the lack of value that they place on Family Medicine obstetrics and the faculty that practice obstetrics.

Upcoming Events



CMNH 2nd Annual Conference
Creating Synergy: Collaboration for
Better Care
Vancouver, BC
May 4-6, 2006



ALARM COURSES 2006

Toronto ON
April 7-8

Montreal QC
April 28-29
(En Français)

Halifax NS
May 6-7

Windsor, ON
June 2-3

Vancouver, BC
June 21-22

Consequently, while I love obstetrics, I feel I must choose between it and other professional goals.

I admit this opinion reflects my personal experience. However, as I look around, I see my academic maternity care colleagues looking much more haggard than my non-obstetrical colleagues.

How can we reverse this trend? Academic institutions must support the faculty who do obstetrics by reducing their other clinical and teaching responsibilities proportionately. Faculty need to be genuinely valued for this essential service. The bottom line is, in the current market, a Family Physician who does obstetrics is a much more valuable commodity than one who doesn't. Consequently, there should be incentives, not disincentives, for recruiting and retaining Family Physicians who practice obstetrics.

We need more Family Medicine leaders like Larry Reynolds and Michael Klein . These are leaders who are in a position to change the University culture towards the practice and teaching of obstetrics and who demonstrate that you can have an illustrious academic career and deliver babies. Most academic Family Physicians are not fairly remunerated for the additional time, level of responsibility and costs that maternity care involves. Our residents see this and consequently Family Medicine Obstetrics is further devalued.

Unless things change, I don't see a bright future ahead for Family Medicine maternity care in Canada. I am hopeful that things will change and I do see signs of progress. If they do, it will be too late for me, my family and I are destined for new challenges and adventures. We are heading down to sunny Australia where I will take up a new position as senior lecturer in General Practice. I will however cherish how maternity care has enriched my personal and professional life and will carry the friendships with others who share my passion into the future with me.

Susan L. Douglas, MD, Interim Chief
Department of Family Medicine, IWK Health Centre

How To Contact Us



Please send your births stories, ideas, feedback, contributions, Conferences etc, to : The Accoucheur at cmnh@cw.bc.ca

The
Accoucheur