

Retraining family physicians to deliver our babies

Nour Redding

Inadequate access to maternity care services is increasingly a problem in Canada owing to health human resource shortages among obstetricians, family doctors, midwives, and nurses who participate in maternity care teams.¹ The issue is particularly troublesome for pregnant women residing in rural and remote areas who often have to travel to receive integrated and safe maternity care.² Considering that family physicians play an important role in providing integrated, comprehensive care to women throughout many periods of their lives, the provision of maternity care services by family doctors is a critical force of influence that can address the issue of adequate access to maternity care.

Factors to consider

It is well established that the number of family physicians providing intrapartum care in Canada has continued to decrease over the past 2 decades.¹ The percentage of family physicians delivering babies in Canada declined from 20% in 1997 to 10.5% in 2010.¹ Surprisingly, results of the 2010 National Physician Survey indicate that a relatively substantial proportion of family physicians are still providing prenatal and postpartum care (42.2% and 54.8%, respectively).³ These statistics raise key questions regarding the emphasis placed on continuity of care in the medical education, training, and practice of family physicians. One would expect that primary care physicians would continue to follow through with the prenatal care they provide women by presiding over the deliveries of their babies.

Before proposing solutions to the problem of decreased intrapartum care, it is important to understand the factors that family physicians cite as reasons for their decreased participation in obstetric care. Many primary care physicians, for instance, have concerns about how delivering infants affects their personal and professional lives. For some, questions surrounding sufficient remuneration exist, while others express unease due to a perceived lack of training and possible threat of malpractice suits.^{1,4-6} However, all family physicians are trained to provide maternity care. Consequently, initiatives should be undertaken to encourage and support family physicians in providing intrapartum care to pregnant women. This could involve a combination of solutions, such as better remuneration, improved education and training, better institutional support, and the use of alternative models of care that promote the provider-patient relationship.

Group prenatal care


Educational interventions for family medicine residents have previously been designed to increase residents' appreciation for and interest in intrapartum care. One such program, developed in North Carolina, expanded the curriculum in maternity care to include more support for teaching and education, better role models in family medicine, participation in a higher volume of deliveries, and increased collaboration with other clinics and professionals.⁷ The study found that among the family medicine residents who received this curriculum, 52% continued to perform deliveries after graduation, compared with 27.5% of residents before the curriculum was introduced, thereby indicating that improved education and better role models can bring about considerable positive outcomes. Canadian studies have also found that physicians who worked with groups of primary care physicians to provide obstetric care services had more flexibility in meeting other personal and professional commitments.^{8,9}

While these methods seem to have a strong potential to change practices and enhance continuity of care among family physicians providing prenatal care, I support a change in prenatal care delivery that I believe will positively influence practitioners to participate in delivering babies. I was initially exposed to the subject of group prenatal care during my master's degree training, which involved exploring the acceptability of group prenatal care to patients and subsequently comparing the outcomes of pregnant women receiving group prenatal care with those women receiving individual prenatal care in a primary care clinic. An extensive literature review that I conducted on the subject of group prenatal care revealed that the model definitely promotes patient-centred care by nurturing self-growth and support between patients and physicians.¹⁰ Moreover, through high-quality interactions and discussions that span a total length of 20 hours over the period of the pregnancy, patients are provided with the opportunity to build trusting relationships with practitioners, thereby improving a physician's sense of reward and satisfaction with care provision.^{10,11}

To date, no studies have assessed the effect of using a group prenatal care approach during residency training to increase the proportion of family physicians who provide intrapartum care after graduating. However, one study has found that patients receiving care from residents who provide group prenatal care tend to have fewer cesarean sections than those receiving regular individual care.¹² It is unclear whether these improved

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birth outcomes are attributable to the improved knowledge, social support, and readiness that women experience as a result of receiving group prenatal care. One could hypothesize that the improvement is a result of the extended time and support that family physicians offer to the pregnant women, which ultimately improves patient self-efficacy.

Despite the fact that further research is undoubtedly needed to investigate whether group prenatal care improves intrapartum practice, the model is comprehensive in its approach to health assessment, education, and support.¹⁰ It allows physicians to provide longitudinal and interpersonal continuity of care, as well as continuity of care within families.¹³ Moreover, it is a channel through which patient-centred care can be delivered effectively. These foundational elements make group prenatal care an attractive alternative to traditional prenatal care practice. Moreover, if research can demonstrate that group prenatal care can increase intrapartum care, this model of education can be implemented in family medicine residency training and ultimately transform the way maternity care services are provided by family physicians. In doing so, the issue of access to adequate maternity care will be addressed in a coordinated, integrated manner, while allowing family physicians to continue playing the special role of provider from the womb to the grave. 

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Competing interests

None declared

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