



## Privileging and consultation in maternity and newborn care

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Canada appears to be headed for a crisis in the number of providers of maternity and newborn care. Family physicians are turning away from maternity care for practical reasons, such as effects on lifestyle, poor and unfair remuneration, and rising malpractice fees. But another important factor is that they are losing their sense of autonomy as maternity care providers.

Family physicians' perception that modern maternity care is complex and technical and "best left to the experts" leads to feelings of powerlessness and being undervalued. These feelings discourage family physicians from providing maternity and newborn care. This paper addresses this growing problem by suggesting ways to define the roles and responsibilities of family physicians (and other providers) according to clear privileging policies and consultation relationships.

We believe structures that foster responsibility, self-regulation, collegiality, and mutual support among providers will promote a higher standard of care than those that encourage dependence of one group of providers on another. For example, consultations, whether between family physicians and specialists or between two family physicians, are likely to be most useful and appropriate when both parties are knowledgeable in their own domains and are mutually respectful.

The settings in which medical students and family medicine residents learn the skills and attitudes required for effective maternity care present a special challenge. Because of the crucial influence of role models, these trainees should experience family practice obstetrics where positive and collegial structures exist. The unintended educational message to trainees who see family physicians functioning in dependent roles is that obstetric practice is beyond their abilities. Choosing not to incorporate maternity and newborn care into future practice is an unacceptable consequence.

To foster positive roles for family physicians in maternity and newborn care, the College of Family Physicians of Canada's (CFPC) Maternity and Newborn Care Committee (MNCC) proposes the following recommendations.

### Recommendations

#### *Department organization and responsibilities.*

These recommendations apply to hospitals (usually larger ones) with separate departments for obstetrics and gynecology, pediatrics, anesthesiology, family medicine, and midwifery.

- Responsibility for care provided by department members should rest with each department head. This should include assessing credentials and granting privileges, quality assurance, disciplining members, and ensuring that policies are carried out by members.
- No department professional group should be responsible for any other.
- Departments should cooperate with each other.
- Where program management is in effect (ie, a maternity and newborn care program), quality assurance will also be carried out on a program basis and address the functioning of the full maternity and newborn care team.
- In departments of family practice where few members provide maternity and newborn care, consider establishing a division of maternity and newborn care for those who do. This division would be responsible for developing maternity and newborn policies for the department as a whole.

Often smaller hospitals (particularly those in rural and remote settings) do not have departmental structures; physicians and midwives are members of a single staff organization. The head or chief of the medical staff is often a family physician but could be from another discipline. Normally in such a setting, assessing credentials and granting privileges is a responsibility of the hospital-wide staff or, occasionally, of the provincial licensing authority.<sup>1,2</sup>

**Policy development.** Regardless of the hospital organizational structure (departmental, program management, or a combination), coherent and consistent policy development for all maternity and newborn care is needed.

- Policies should be developed by a multidisciplinary committee consisting of obstetricians, pediatricians, anesthesiologists, family physicians, nurses, midwives, and administrative representatives. Each department should be represented. This would be consistent with the national guidelines for Family-Centred Maternity and Newborn Care.<sup>3</sup>
- Policies should apply equally to all disciplines.
- The chair of the committee could be a member of any of the constituent disciplines.

**Granting privileges.** Decisions on privileges should be based on evidence and best practice standards. The CFPC's MNCC supports the CMA policy summary "The Physician Appointment and Reappointment Process."<sup>4</sup> Key principles in this policy are as follows.

- All processes should be fair, equitable, documented, transparent, and just.
- Regular evaluation of appointed physicians should be conducted by the appropriate department head.
- The quality of a physician's care is the most important criterion to consider at time of appointment, reappointment, and granting of privileges.
- A physician's credentials, skills, expertise, and quality of care, as judged by peer assessment, should be considered during the process.

In particular, the following guidelines should be considered for maternity and newborn care.

- Maternity and newborn care privileges should be granted according to skill and expertise. No evidence shows that any particular training or clinical experience produces ideal maternity care providers.
- No evidence supports having stated lower or upper limits of births attended or procedures performed to maintain privileges.<sup>5</sup>
- Privileging should always take place in the context of departmental and institutional quality assurance and risk management programs.
- Risk management courses, such as Advanced Life Support in Obstetrics (ALSO) and Advances in Labour and Risk Management (ALARM) are encouraged and desirable but should not be mandatory.
- A probationary period could be used when providers are unable to document adequate previous

experience. This could assist providers in gaining confidence or incorporating new or advanced skills into their practice. Providers should have input into the choice of probation supervisor, who could be anyone qualified for that task.

**Scope of privileges.** A distinction is made here between basic skills for which any family physician providing maternity and newborn care should be granted privileges and more advanced skills that should be treated on an individual basis. The following are the basic skills:

- spontaneous term singleton vertex labour and birth;
- induction of labour for postdates pregnancy or ruptured membranes at term with no evidence of fetal compromise<sup>6,7</sup>;
- basic fetal surveillance;
- assessment of placental function by ordering and interpreting appropriate clinical and laboratory investigations;
- management of dystocia in the first and second stages of labour by nonpharmacologic and pharmacologic means, including oxytocin<sup>8</sup>;
- management of shoulder dystocia;
- outlet and low vacuum extractor or forceps-assisted births;
- repair of laceration or episiotomy;
- management of postpartum hemorrhage;
- vaginal birth after cesarean section (VBAC);
- examination and care of newborns; and
- basic neonatal resuscitation, including intubation and management of meconium.

Where any of these skills, particularly the more complex ones, are underdeveloped or where experience is limited, family physicians are encouraged to seek mentoring from other family physicians or consultants or take ALSO or ALARM courses. Further specific privileges for more advanced skills can be granted to individual family physicians following appropriate review of previous training and experience.

**Consultations.** Consultation plays an integral role in all health care settings. Principles of consultation have been well described, both generally and in obstetrics.<sup>9,10</sup> Key principles for maternity and newborn care include the following.

- Mandatory consultation should not be part of departmental policy because family physicians vary greatly in skill and expertise and because a policy of mandatory consultation has never been shown to improve care. It should be assumed that responsible physicians will seek

- consultation when required, according to individual clinical situations.
- There are circumstances when consultation might be seriously considered, either from a specialist or a family practice colleague. Consultation should be obtained when physicians lack the requisite skill or experience, when diagnosis is in doubt, or when the problem is serious or life threatening.
  - A quality assurance process should be in place; risk management protocols should be developed.
  - All consultations should be formally requested with clarification of who is to assume the team leadership for ongoing care. Informal and often incomplete "corridor consultation" pertaining to particular patients should be discouraged for the medical and legal protection of all those involved. This is not meant to discourage collegial discussions about patient care principles and general management issues but rather to ensure consultants have the benefit of a complete picture before offering an opinion.
  - Family physicians should remain part of the care team both during and after consultation even in situations where care has been transferred.

## Conclusion

One of the goals of institutional maternity and newborn care should be to create a mutual sense of respect and collegiality among all those providing care. An important element in reaching this goal is to establish an appropriate system of privileging and consultation that recognizes the complementary expertise and responsibilities of individual care providers and disciplines. The functioning of such a system should be evaluated as part of ongoing quality assurance and risk management programs. Within this context, family physicians and all other members of the team can provide excellent care well within their capabilities. ♦

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## References

1. Iglesias S, Grzybowski S, Klein MC, Gagné GP, Lalonde A. Rural obstetrics. Joint position paper on rural maternity care. *Can Fam Physician* 1998;44:831-7 (Eng), 837-43 (Fr).
2. Hutten-Czapski P, Iglesias S, Baskett T. Joint position paper on training for rural family practitioners in advanced maternity skills and caesarean section. SOGC Joint Position Paper No. 80. *J SOGC* 1999;21(10):985-94.
3. Health Canada. *Family-centred maternity and newborn care; national guidelines*. Ottawa, Ont: Minister of Public Works and Government Services; 2000.
4. CMA Policy Summary. Sommaire de politique de L'AMC. The physician appointment and reappointment process. Le processus de nomination des médecins et de renouvellement de leur mandat. *Can Med Assoc J* 1998;158(2):249-54.
5. Society of Obstetricians and Gynaecologists of Canada. *Number of deliveries to maintain competence*. Policy statement No. 58; 1996 Nov. Available from: Society of Obstetricians and Gynaecologists of Canada via [http://www.sogc.org/SOGCnet/sogc\\_docs/common/guide/index\\_e.shtml](http://www.sogc.org/SOGCnet/sogc_docs/common/guide/index_e.shtml). Accessed 2000 Jun 2.
6. Society of Obstetricians and Gynaecologists of Canada. *Induction of labour*. Policy Statement No. 57; 1996 Oct. Available from: Society of Obstetricians and Gynaecologists of Canada via [http://www.sogc.org/SOGCnet/sogc\\_docs/common/guide/index\\_e.shtml](http://www.sogc.org/SOGCnet/sogc_docs/common/guide/index_e.shtml). Accessed 2000 Jun 2.
7. Society of Obstetricians and Gynaecologists of Canada. Maternal-Fetal Medicine Committee. *Post-term pregnancy*. Committee Opinion No. 15; 1997 Mar. Available from: Society of Obstetricians and Gynaecologists of Canada via [http://www.sogc.org/SOGCnet/sogc\\_docs/common/guide/index\\_e.shtml](http://www.sogc.org/SOGCnet/sogc_docs/common/guide/index_e.shtml). Accessed 2000 Jun 2.
8. Society of Obstetricians and Gynaecologists of Canada. *Dystocia*. Policy Statement No. 40; 1995 Oct. Available from: Society of Obstetricians and Gynaecologists of Canada via [http://www.sogc.org/SOGCnet/sogc\\_docs/common/guide/index\\_e.shtml](http://www.sogc.org/SOGCnet/sogc_docs/common/guide/index_e.shtml). Accessed 2000 Jun 2.
9. Ross LG, College of Family Physicians of Canada, Task Force on the Relationship between Family Physicians and Consultants, Royal College of Physicians and Surgeons of Canada. *The relationship between family physicians and specialist/consultants in the provision of patient care*. Mississauga, Ont: The College of Family Physicians of Canada; 1993.
10. Reid AJ, Carroll JC, Ruderman J, Murray M. Consultation in family practice obstetrics. *Can Fam Physician* 1995;41:591-8.