

# A Transition Phase for Obstetrics

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After taking a look at the big picture, by means of our November FIGO issue, it is reasonable for us to focus again on domestic issues. The international concerns of women's health—maternal mortality, perinatal mortality, the scourge of HIV/AIDS, reproductive rights and freedoms, and education—are enormous issues, to be sure. But Dorothy Shaw, the new President of FIGO (and the first Canadian, and the first woman, to hold the position) has tackled enormous issues before. She will do us proud, and women throughout the world will benefit. To paraphrase another great Canadian: just watch her!

So, back in Canada: another year has gone by, and worry about the present and future availability of maternity services continues. While clinicians, strategists and policy-makers deliberate about what will ensure at least some level of maternity service for all Canadian women, we learn from the study reported by Marie-Josée Bédard and colleagues in this issue that less than 10% of medical students in Québec plan to offer full obstetrical services in their future practices. For many, their clerkship experience was apparently a negative influence: the number of students who decided, on the basis of their experience, that they would offer obstetrical services in the future was less than half the number deciding that they did not want to do so. Dr Bédard and her colleagues stress the importance of attention to mentoring of medical undergraduates by family physicians and residents, and ensuring that students who witness or participate in critical events with adverse outcomes undergo a debriefing to put such events in context. Such recommendations are critical; if we don't pay careful attention to how trainees—both undergraduates and family practice residents—perceive the practice of obstetrics, everyone will pay the price.

However, even though we can try to optimize the experience of trainees in departments of obstetrics and gynaecology and family practice, many students will enter medical school with already formed perceptions of pregnancy and

childbirth. When I entered medical school in 1966, rates of fecundity were still at a post-war high, labour was a noisy, narcotic-and-oxytocin-drenched event, and Caesarean section (performed under general anaesthetic) was a rarity. The conduct of labour and delivery was the purview of the unflappable nurse-midwives, and physicians appeared only for complicated deliveries or for perineal repairs. For those of us in training, obstetrics was seen as a craft to be learned, rather than a branch of medicine.

But then came epidural anaesthesia and fetal heart monitoring, followed by more direct fetal scalp pH assessment, and the craft began transforming into a medical event. We began seeing fetal distress where we had not previously recognized it. Rates of Caesarean section began to rise. Adverse fetal outcomes were deemed to be avoidable, and rates of litigation against physicians and hospitals accelerated. To make matters worse, in 1979 obstetric practice was deemed the least evidence-based of all branches of medicine. Not only were obstetricians losing what pride they had had in the art of conducting a difficult vaginal delivery, they were being chastised by their peers for practising poor-standard medicine.

It is to the obstetricians' great credit that they swallowed their pride and switched their focus to concentrate on asking the right questions. As a result, two things happened: obstetrical practice became respectable among the medical specialties because of its genuine evidence base, and Caesarean section became the default management for a delivery whose course deviates from an ideal standard. So although we can expect that the appeal of obstetrics as a career (or part of a career) in medicine will rise because it has become so evidence-based, it will be at the expense of increasing public health cost and possibly greater risk for patients, not to mention a loss of technical satisfaction for practitioners.

The increasing place of Caesarean section as an alternative to vaginal delivery, as fertility rates fall and the average maternal age rises, is perhaps inevitable—but nevertheless difficult to accept. We all feel some ambivalence about the idea of women seeking delivery by Caesarean section when there is no obstetrical indication for it. This ambivalence

extends to pregnant women as well, as demonstrated in the findings of the study reported by Susan Pakenham and co-authors in this issue. Their survey of pregnant women in Kingston showed that the majority would not want to have an elective Caesarean section themselves, but they felt that the option should be available for those who did want it. The advantages to women and their obstetricians of permitting elective Caesarean section are fairly obvious. The disadvantages are what remain unclear, and it is only a matter of time before evidence from randomized trials sheds light on the issue. Who will be first?

At the end of another year, we are again heavily indebted to all who have contributed to the production of JOGC. This includes not only our authors and members of the Editorial Board but also our reviewers, whom we acknowledged at a very successful reception at the SOGC Annual Clinical Meeting in June. I continue to be astonished by the number of people who are prepared to commit time and expertise, without remuneration, to the *Journal's* production. On behalf of the editorial staff, thanks to all of you, and we hope that 2007 brings professional satisfaction and personal harmony!