Spending Time with Patients in Labor

Commentary by MARTHA C. CARLOUGH, MD, MPH, and AMI GOLDSTEIN, MSN, CNM
Department of Family Medicine, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina

Case scenarios are written to express typical situations that family physicians may encounter; authors remain anonymous.

Please send scenarios to Caroline Wellbery, MD, Department of Family and Community Medicine, Georgetown University Medical Center, 212 Kober Cogan Hall, 3800 Reservoir Rd. NW, Washington, DC 20007. Materials are edited to retain confidentiality.

Case Scenario

I work in an office where there are a lot of obstetric patients, and I feel privileged as a family physician to be able to perform deliveries. But I also have a full-spectrum practice and a private life. Many of my patients are on the teaching service for a nearby residency program. The residents take care of my patients and call me around the time of delivery. Sometimes I am there well ahead of time, sometimes I make it just in time, and at other times I arrive after the delivery. I want to be a good role model for the residents, and I notice that they are often in and out of the room for their patients' deliveries. What is the appropriate amount of time to spend with my patients who are in labor? How do I discuss this with my patients?

Commentary

This scenario raises several key questions that are important not only to patient care, but also to physicians' quality of life and satisfaction with practice. First, what are the critical roles for the family physician during prenatal care, labor, and birth? Second, what is the evidence for supportive care during childbirth? Lastly, how does a busy family physician integrate obstetric care, which is by nature unpredictable, into practice and daily life?

Physicians are typically trained to be most concerned about and prepared for the moment of birth, but the majority of supportive care and decision making that affect birth outcomes occur much earlier. The hours of labor and birth are only a small part of the care of pregnant women and their families. Prenatal care includes health education, empowerment, and connections with physicians and the hospital system in preparation for birth. The relationship that develops during the course of prenatal care forms a foundation of trust that the physician and patient will draw on during the birthing process.

During labor and delivery, four key components have been consistently identified as contributing to maternal satisfaction: personal expectations, support from caregivers, the quality of the physician-patient relationship, and patient involvement in decision making. These factors seem to be more predictive of women's satisfaction levels than the experience of pain or pain relief.[1]

Women who report satisfaction with their labor and birth express having a sense of control and having their expectations met.[2] The family physician can guide the conversation during prenatal visits about expectations under ideal circumstances versus what may happen if complications arise. Various tools, such as birth plans and case scenarios, can facilitate the conversation about physician availability and the realities of a busy hospital labor and delivery unit. It is important for physicians to be aware of their practice style and communicate their own approach to labor management. This allows women and their families to evaluate whether this approach is likely to meet their needs.[3] It also increases patients' sense of control over the birth experience, and helps the family physician not feel that he or she is disappointing the patient.

There is little specific evidence on the effects of the physician's presence during labor and birth. However, there is clear evidence of positive outcomes associated with companionship during labor. In a retrospective study of women in Finland who had midwifery care, women with an attentive, empathetic, and calm midwife reported more positive childbirth experiences.[4] A multi-site Cochrane review that ▶

included more than 13,000 women found that those who had continuous support during labor had shorter labors, fewer interventions, a reduced incidence of assisted or surgical deliveries, and higher levels of satisfaction.[5] In this systematic review, the effects were more pronounced when the support was provided by nonhospital staff female companions. The positive impact of labor support continues after childbirth, with studies documenting lower rates of postpartum depression, higher newborn Apgar scores, and increased rates of exclusive breastfeeding.[6]

Being unaccompanied during labor and birth is associated with a risk of adverse outcomes. Women who are alone during labor and birth have a higher incidence of epidural use and cesarean delivery, and lower satisfaction postpartum.[7] Although the physician acting as the main source of labor support may not be necessary or even desirable for some women, this evidence reinforces the need for the physician to ensure that appropriate support is available, because even intrapartum nurses may spend only about 10 percent of their time in this role.[8] Expectations for physician presence during labor should be communicated with patients in advance.

So, does it make sense for family physicians to spend time with laboring women when there are competing demands? With little evidence available on the outcomes of physician presence, expert opinion and local standards need to be considered. Recent strategies to improve patient safety, reduce medical errors and liability, and improve the functioning and communication of the entire health care team are increasing expectations for the in-house presence of physicians.[9] Most hospitals have at least general guidelines for when the primary physician must be in-house, as well as obstetric and anesthesia back-up. If guidelines are not established, these are important discussions for the medical staff to improve communication and decrease the potential for conflict and liability when responsibility is unclear.

When a woman in labor has a designated support person, the tools to cope with the challenges she might face, and the ability to express her needs, the physician's role may be minimal. However, the patient must be cared for by competent and responsive nurses and other physicians, including resident physicians. If support persons are not available, if there is not a well-developed relationship between the patient and physician, or if the resident physician needs mentoring and support, it is important for the primary physician to be more involved. This will likely mean more time at the bedside during labor. These are the situations where an investment of the physician's time and energy can make the most difference, paying off in better outcomes and improved satisfaction for women, their families, and even the physician. Family physicians practicing maternity care should explicitly recognize the situations where their presence is most important, and commit themselves to being present for these women, either by providing primary support or by mentoring resident physicians in this role.

Address correspondence to Martha C. Carlough, MD, MPH, at Martha_carlough@med.unc.edu. Reprints are not available from the authors.

Author disclosure: Nothing to disclose.

REFERENCES

1. Hodnett E. Pain and women's satisfaction with the experience of childbirth: a systematic review. *Am J Obstet Gynecol.* 2002;186(5 suppl nature):S160-S172.
2. Goodman P, Mackey MC, Tavakoli AS. Factors related to childbirth satisfaction. *J Adv Nurs.* 2004;46(2):212-219.
3. Douglas S, Cervin C, Bower KN. What women expect of family physicians as maternity care providers. *Can Fam Physician.* 2007;53(5):874-879, 874.
4. Tarkka M, Paunonen M, Laippala P. Importance of the midwife in the first-time mother's experience of childbirth. *Scand J Caring Sci.* 2000;14(3):184-190.
5. Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. Continuous support for women during childbirth. *Cochrane Database Syst Rev.* 2007;(3):CD003766.
6. Sauls D. Effects of labor support on mothers, babies, and birth outcomes. *J Obstet Gynecol Neonatal Nurs.* 2002;31(6):733-741.
7. Essex HN, Pickett KE. Mothers without companionship during childbirth: an analysis within the Millennium Cohort Study. *Birth.* 2008;35(4):266-276.
8. Gale J, Fothergill-Bourbonnais F, Chamberlain M. Measuring nursing support during childbirth. *MCN Am J Matern Child Nurs.* 2001;26(5):264-271.
9. Veltman LL. Getting to havarti: moving toward patient safety in obstetrics. *Obstet Gynecol.* 2007;110(5):1146-1150. ■