donors and overcome the problem of finding a donor for non-white patients. Currently the Anthony Nolan Research Centre is recruiting donors from ethnic minorities in Britain.⁴ The development of gene therapy should result in this treatment eventually replacing allogeneic bone marrow transplantation for inborn errors of metabolism, immunodeficiency states, and haemoglobinopathies.³⁴

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Controversies in Management

Should obstetricians see women with normal pregnancies?

Obstetricians should be included in integrated team care

Patrick Walker

This is the fifteenth in a series of articles examining some of the difficult decisions that arise in medicine

The expert maternity group which suggested that obstetricians should not see normal pregnancies¹ was, perhaps, unrepresentative. About 700 000 women each year in England and Wales are booked for care under a named consultant obstetrician. Yet the expert committee did not request formal input and had no representative from the Royal College of Obstetricians and Gynaecologists.²

Normality with respect to pregnancy, especially first pregnancy, is a retrospective diagnosis.³ If it could be confirmed that a woman would not require medical advice or help at any stage in a pregnancy, an obstetrician might not be strictly necessary. But this is not possible. In addition, unless obstetricians attend normal pregnancies they will have nothing to judge against when they look after women whose pregnancies are progressing abnormally. Women with abnormal pregnancies must be looked after by a someone who is regularly exposed to the full range of physiological and pathological patterns of pregnancy and labour. Would you be confident to be looked after by a cardiologist who had not listened to a normal heart for 20 years or a surgeon who had not seen normal anatomy since medical school?

The midwife alone cannot be gatekeeper. A team

approach is needed, including the midwife, general practitioner, and consultant. This ensures lateral as well as longitudinal continuity of care whatever arises.

Fire fighting obstetricians

The obstetrician as a fire fighter is also an untenable proposition. It does not make common or clinical sense and it is inappropriate for the empathic care of pregnant women. Even if we accept that midwives are always as good as doctors at spotting problems in pregnancy and labour at an early and appropriate time, the fire fighter strategy remains inappropriate. When problems arise in pregnancy, many of which require emergency treatment, it is one of the most stressful moments of a women's life. If it is important that women are cared for in labour by someone they know—as asserted by those arguing for midwife only care—surely it is even more essential that they know their obstetrician if more dangerous and interventional procedures are required.

In genuine team midwifery women whose pregnancies in retrospect are normal may have met the obstetrician only at booking and then received an informal courtesy visit in early labour from the

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obstetric team on call. Women with problems will have also received midwifery care but can have a seamless transition to an obstetrician. I believe that there could be no criticism of such a model unless there is a hidden agenda.

Hidden agenda

As in many other areas of medicine obstetricians have introduced monitoring and interventionalist strategies to the management of pregnancy and labour without full scientific evaluation. This has led to a medicalisation of normal pregnancy and resulted in an increase in the rate of induction and caesarean sections, many of which could be classified as unnecessary. The hidden agenda of those who propose that obstetricians should not see women with normal pregnancies is not continuity of care and extended choice for women but rather to reduce the level of intervention by keeping women away from obstetricians. It would be much better if women, midwives, and obstetricians all acknowledged that a problem exists. The appropriate studies could then be done to determine which interventions are required for the safest and most acceptable care. If nothing else this approach would have the advantage of being intellectually honest.

Uniting the professions

Finally, and perhaps most persuasively, the main reason that women should not be cared for only by midwives is that it will drive a wedge between midwives and obstetricians. Obstetricians need the help and support of midwives throughout their career. From instruction in normal labour and delivery in medical school to shared responsibility on the labour

ward and in the clinic in later life the two professional groups should work hand in hand. When things go well and when outcomes are unexpectedly poor both groups need that mutual support. If obstetricians do not see normal pregnancies we run the severe risk of ending this tradition of cooperation to the detriment of everyone, especially pregnant women.

Whose decision?

In the end though, who should decide? Well intentioned politicians and their select committees, prey as always to the biased views of well organised lobbyists? Those who some call modern obstetricians but who are in fact antenatal paediatricians who not unreasonably have limited interest in normal women? Should it be radical midwives wishing to extend their own sphere of influence or feminists working to their own political agenda? Should it be paternalist obstetricians attempting to save their roles and their view of a changing world? No, none of these. The choice should be left to pregnant women themselves. If they are asked the appropriate question: "Do you wish to be looked after by a team of carers, including both midwives and doctors whom you will meet during the course of your pregnancy and who will work together to provide care for you whether your pregnancy is complicated or not?" They will answer yes. If they are appropriately informed pregnant women would say that obstetricians should see normal pregnancies.

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Obstetricians should focus on problems

David K James

The provision of care for pregnant women is changing enormously. Many of these changes were under way before the well publicised Winterton and Cumberlege reports.^{1,2} One of the changes is that women with normal pregnancies increasingly see their general practitioner and midwife for most of their care and see the obstetrician less often. In some instances women do not see an obstetrician at all. I think that this trend is to be encouraged. I believe that in the ideal world women with normal pregnancies need not see an obstetrician for four reasons—consumer, philosophical, scientific, and evolutionary.

Consumer argument

Several studies have shown that most women with normal pregnancies do not wish to see an obstetrician.^{3,4} Naturally, it is difficult for such studies to be free of bias. It depends who asks the questions, how they are asked, and how they are phrased. Nevertheless, I am not aware of any survey which claimed that most women would wish to see an obstetrician if their pregnancy were normal.

Philosophical argument

Care in pregnancy has four aims (box).⁷ General practitioners and midwives are perfectly able to fulfil the first three aims (providing reassurance, treatment

of minor problems, and undertaking screening). There is no evidence that obstetricians are any better at performing these functions in otherwise normal pregnancies. In contrast, women with problems in pregnancy require the skills of an obstetrician, and it is at these women that an obstetrician's efforts are best directed.⁸

Scientific argument

Controlled studies have shown that the outcome of women with normal pregnancies seen by an obstetrician is no better than that when no obstetricians are involved.^{9,10} It should be stressed, however, that in such studies the normal pregnancies were managed

Aims of care in pregnancy⁷

- 1 To provide advice, reassurance, education, and support for the woman and her family
- 2 To deal with the minor ailments of pregnancy
- 3 To provide an ongoing screening programme (clinical and laboratory based) to confirm that the woman continues not be at risk
- 4 To prevent, detect, and manage those problems and factors that adversely affect the health of the mother or her baby

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