Maternal–fetal medicine subspecialists and obstetric physicians: a match made in heaven or too many cooks?

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I should say first of all that I am an Obstetrician and Gynaecologist with a subspecialty qualification in maternal–fetal medicine (MFM) and my opinions are my own! A large majority of doctors who enter Obstetrics and Gynaecology do so for a love of the duality this area provides. One is faced with managing medical problems and finding non-invasive solutions combined with the challenges of being a surgeon and using ones' surgical skills to heal. We get the best of both worlds and can treat a wide range of conditions with our skill set. This mixture of skills means we can expect to be autonomous in our care of women. Those of us who then subspecialize into MFM are generally a very driven and altruistic group, otherwise we would specialize in more lucrative areas of Obstetrics and Gynaecology.

As described in the last edition of *Obstetric Medicine*,¹ doctors entering the field of Obstetric Medicine are physicians, with their mighty brain power, who are captivated by the extra challenge of the altered environment of pregnancy. When these two groups meet to care for women with medical disorders of pregnancy, two groups of high functioning, driven and challenge seeking Doctors are brought together. So how do the two disciplines work together?

I have worked in several maternity units both with and without Obstetric Physicians. At National Women's Health in Auckland we have a vibrant and well staffed MFM department and separate Obstetric Medicine department. Women are seen in outpatient clinics by both disciplines in a joint clinic and are then discussed after where plans can be changed as a result. Women who are inpatients are under the care of an MFM specialist but there will be close consultation where necessary with an Obstetric Physician and a weekly meeting to discuss issues and ongoing care. In general, the system works very well and is of great benefit to the woman's care as she has all her care under one roof rather than being shunted off to different clinics at different times.

Not surprisingly, we have our moments when strong personalities clash. We can end up in debates where it really feels as if there are too many cooks involved. Within MFM and Obstetric Medicine there is a large area of clinical overlap and then there are also areas which are clearly the domain of one or the other discipline. Questions such as 'How should the Induction of Labour be performed?' and 'Is this cardiotocogram recording acceptable?' are the domain of the MFM doctor. An Obstetric Physician who enters this debate will be told they are straying into MFM territory! On the other hand, questions like 'Is this ECG normal?' and 'What is the current recommended treatment for rheumatoid arthritis?' will and should be the provenance of the Obstetric Physician. Having said that, in the Royal Australian and New Zealand College of Obstetrics and

Gynaecology MFM subspecialty curriculum, there is expected to be some knowledge in these Medical areas, though an Obstetric Physician will generally have a better knowledge in the majority of these areas. It is the grey areas of overlap where most communication issues reside, e.g. severe pre-eclampsia, antiphospholipid antibody syndrome and infections in pregnancy (which may also have fetal implications and can then involve the MFM doctor's fetal medicine skill set).

So how do we make this work in practice? In my experience, as with most things in life, it comes down to compromise and communication from both parties. I have always said that if you keep the woman at the centre of your thoughts you cannot go wrong. So if a colleague from a different discipline has an idea, listen as it may be a good one even if you think it is not their job to have that idea.

A few years ago I spent a year in a hospital in the UK without Obstetric Physicians, as part of a job swap. I was the consultant who specialized in all things haematological, renal and infectious during that time. A woman would come to see me and I would search through the notes to see what the relevant Physicians had said at their last meeting with the woman. These were all generalists who treated only a handful of Obstetric patients a year in their clinics and often did not really understand my urgency for information and planning. They often shied away from excellent treatments as the woman was pregnant, even though we had good data on the drugs which showed the benefit outweighed the risk. Having come from an evidence-based academic unit, I was surprised to find myself more knowledgeable in many areas than the subspecialty Physicians, e.g. potential risk of permanent loss of renal function after pregnancy in a woman with glomerulonephritis. By the end of the year I had developed the links I needed and managed to secure one Physician from each discipline who was prepared to take my insistent phone calls to their personal cell phone, but I suspect they were glad I left. It worked out okay, but I really felt that our system in Auckland was far superior even with the occasional spats that we seem to have.

One of the disadvantages of having Obstetric Physicians in a Maternity Unit can be that Junior Doctors stop taking responsibility for managing and learning about medical problems in pregnancy as part of their core work. I have often been called by an Obstetric Registrar saying they are off to call the Obstetric Physician on call about a possible pulmonary embolus case when it is clear that their own assessment would justify proceeding with imaging. They often have not even examined the woman. I think this is an issue which probably occurs in any unit with Obstetric Physicians and is an issue MFM doctors face when jointly managing cases with other specialists for example assisting the generalist obstetrician

with the management of twins with growth restriction. As doctors subspecializing in a small niche area whether MFM or Obstetric Medicine, it is important we do not allow our generalist colleagues to bow out of areas which should remain under the care of the generalist with support from us as needed.

So my vote is to have units with both disciplines, but clear communication, no straying over the line and a hands-off

approach with areas which can be managed by a generalist Obstetrician with appropriate support.

REFERENCE

- 1 Powrie R. Good company. *Obstet Med* 2012;5(4):139–40