



## WPI 11

# Obstetrician's Competence and Performance

“Competence” may be defined as the ability to use a set of skills and knowledge gained in an area of expertise. “Performance” is the application of that knowledge and skill. Competency in any branch of medicine must be combined with the application of acquired skills and knowledge into a safe and contemporary practice.<sup>1</sup> Competence to manage obstetric cases is not dependent on the annual number of births attended by the practitioner and such numerical considerations should not be an element of any credentialing program.

Continued hospital obstetric privileges should depend on the applicant's performance as demonstrated in peer review audits and by participation in a Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) approved self-directed program of continuous professional development. That program should reflect the requirements and responsibilities of the practitioner in relation to the complexity of the obstetric caseload. It may include activities such as participation in workshops aimed at updating appropriate skills. It should include participation in some form of practice audit by peers.

Over a number of studies, attendance at a minimum number of births per annum has not been shown to be directly related to performance.<sup>(2-9)</sup> Such numerical requirements fail to take into consideration the previous experience of the obstetricians, the complexity of the cases undertaken, the setting and organization of the practice, the use of risk management programs, such as standardised obstetric protocols and the degree of support provided by obstetric and non-obstetric specialist colleagues. This is confirmed by Canadian Studies.<sup>3</sup>

Peer review activities, reflective learning and practice modification techniques rather than a pure numerical delivery quota better assess clinical competency. A high number of deliveries by a busy solo practitioner may be counterproductive to performance as it leaves little time for reflective practice, continuing education, rest, family life and leisure. Group private practice arrangements are a means of reducing chronic fatigue and affording each obstetrician the necessary time for maintenance of professional standards. Lack of rest has been demonstrated to reduce clinician vigilance in emergency medicine.<sup>10</sup>

Instruments for peer assessment of medical practitioners' competence still require further validation.<sup>11</sup> However competence includes not only medical expertise and clinical decision making: communication skills, interpersonal skills, collegiality, professionalism and a demonstrated ability to improve continuously are also necessary components. It seems likely that these latter aspects may be reliably assessed using feedback from colleagues, and patients.<sup>12</sup>

## References

- 1 Rethans JJ, Norcini JJ, Baron-Maldonado M, Blackmore D, Jolly BC, LaDuca T, Lew S, Page GG, Southgate LH. The relationship between competence and performance: implications for assessing practice performance. *Medical Education*, 2002; 36(10): 901-9.

2. Wheeler RC, Reiter KL, Mead S, Burkhardt JH, Bushee GR, Sunshine JH. The use of volume standards in health services. *Quality Management Health Care*, 2001; 9(4): 47-62.
3. Gagne GP, Grzybowski S, Inglesias S, Klein S, Lalonde A. Joint position paper on rural maternity care. Joint Working Group of the Society of Rural Physicians of Canada (SRPC), the Maternity Care Committee of the College of Family Physicians of Canada (CFPC), and the Society of Obstetricians and Gynaecologists of Canada (SOGC) *Soc Obstet Gynaecol Can* 1998; 20:393-8; 399-405.
4. Tilyard MW, Williams S, Seddon RJ, Oakley ME, Murdoch CJ. Is outcome for general practitioner obstetricians influenced by workload and locality? *New Zealand Medical Journal*, 1988; 101(844): 207-9.
5. Klein MC, Spence A, Kaczorowski J, Kelly A, Grzybowski S. Does delivery volume of family physicians predict maternal and newborn outcome? *Canadian Medical Association Journal*, 2002; 166 (10): 1257-63.
6. Reid AJ, Carroll JC, Ruderman J, Murray MA. Differences in intrapartum obstetric care provided to women at low risk by family physicians and obstetricians. *Canadian Medical Association Journal*, 1989; 140(6): 625-33.
7. Hueston WJ, Applegate JA, Mansfield CJ, King DE, McClafflin RR. Practice variations between family physicians and obstetricians in the management of low risk pregnancies. *Journal of Family Practice*, 1995; 40(4): 345-51.
8. Deutchman ME, Sills D, Connor PD. Perinatal outcomes: a comparison between family physicians and obstetricians. *Journal of American Board of Family Practice* 1995;8(6): 440-7.
9. Poma PA. Effects of obstetrician characteristics on caesarean delivery rates. A community hospital experience. *American Journal of Obstetrics and Gynecology*, 1999; 180(6): 1364-72.
10. Frey R, Decker K, Reinfried L, Klosch G, Saletu B, Anderer P, Semlitsch HV, Seidler D, Laggner AN. Effect of rest on physicians' performance in an emergency department, objectified by electroencephalographic analyses and psychometric tests. *Critical Care Medicine*, 2002 30(10):2322-9.
11. Evans R, Elwyn G, Edwards A. Review of instruments for peer assessment of physicians. *BMJ*, 2004;328:1240-1244.
12. Violato C, Lockyer J & Fidler H. Multisource feedback: a method of assessing surgical practice. *BMJ*, 2003;326:546-548.
13. Davis DA, Thomson MA, Oxman AD, Haynes RB. Changing physician performance. A systematic review of the effect of continuing medical education strategies. *JAMA*, 1995 Sept; 700-705.

## Links to College Statements

[Fatigue and the Obstetrician/Gynaecologist \(WPI 18\)](#)

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