Maternity care: a duplication of resources

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THE care of childbearing women is shared by many health professionals, in particular by general practitioners, midwives and obstetricians. Obstetricians should be responsible for the care of women with obstetric complications, but there is an overlap in the respective responsibilities of midwives and general practitioners for the care of women who experience a normal pregnancy, labour and puerperium. Some of the implications of this overlap are considered here using data from a research project which explored the responsibilities of midwives for normal maternity care in relation to the responsibilities of medical staff.[1] The research was commissioned and funded by the Department of Health and Social Security, and the data were obtained by means of questionnaires sent to staff in 60 health districts, randomly selected from the health authorities of England and Wales.

A midwife is qualified to assess the health of the mother and the growth and development of the fetus during pregnancy, and to recognize signs of abnormality which necessitate referral to medical staff for advice and treatment. However, the majority of community midwives who participated in the research project played a very restricted role in the assessment of pregnancy. They undertook various aspects of normal antenatal care — interviewing and weighing the women, urine testing, measuring blood pressure and carrying out the abdominal examination. However, as shown in Table 1, nearly two-thirds of the midwives worked in clinics where the general practitioner carried out the abdominal examination, even if it had already been carried out by the midwife. It is after this examination and when the results of the other investigations are available that the overall assessment of pregnancy is made. The midwife is qualified to make this assessment on her own responsibility, but if the general practitioner takes on this responsibility, then the main clinical role of the midwife is to assist the doctor by ensuring that all the information necessary to make the assessment is available. The data in Table 1 show that 29.3 per cent of the respondents were usually responsible for the abdominal examination at some or at all of the clinics in which they worked. These were mainly midwives who had the opportunity to hold their own clinics, at which women were examined by a general practitioner only if this was requested by the midwife.

This underuse of the clinical skills of the majority of community midwives wastes resources; midwives are trained at considerable cost, but once qualified that part of their training concerned with decision making in pregnancy is often wasted. It could also be argued that financial resources are wasted in that money is spent training midwives to provide antenatal care for women with low-risk pregnancies and they are then paid a salary to provide this care once in practice, yet many general practitioners are also paid to provide care for the same group of women.

Midwives are also qualified to monitor and assess the progress of labour, to be responsible for normal deliveries and to recognize the deviations from the normal which require medical assistance. However these skills may be duplicated by those of the general practitioner. Although the trend towards hospital confinement has led to a substantial reduction in the number of women delivered by community midwives at home, in recent years midwives have had the opportunity to deliver women in hospital — the number has risen from five per midwife in 1972 to eight per midwife in 1979.[2] However, in 1981 it was suggested by a Joint Working Party of the Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners, that there should be an increase in the proportion of general practitioners trained to provide full care, and that 'an expansion of general practitioner beds within or adjacent to specialist units in all districts would allow a substantial number of women to be cared for in labour by general practitioners with specialist assistance readily available'.[3]

If schemes are implemented whereby more general practitioners are involved in the full care of women with low-risk pregnancies then they will be duplicating the skills of midwives who are at present responsible for the deliveries of the majority of these women — this includes midwives working in hospital and those community midwives who bring women into hospital for delivery under 'domino' schemes. Intrapartum care will then suffer the same duplication of professional skills and resources which already exists for antenatal care.

It is now often the case that the responsibility for maternity care is shared by the consultant and the general practitioner. Thus, the care of women with high-risk pregnancies is assigned to the obstetrician and the care of low-risk pregnancies to the general practitioner with intermittent assessment by the obstetrician. There is therefore a duplication of resources in our system of maternity care. We train a body of professionals — midwives — to provide normal childbearing women with clinical care, advice and support, and yet at the same time we assign this care to general practitioners. Perhaps the role of the general practitioner in the provision of maternity care should be reduced or midwives trained for a less independent role than that at present. It is necessary to know whether a system which divides the responsibility for maternity care primarily between the obstetrician and the general practitioner is more effective than one which divides this responsibility between the obstetrician and the midwife. An evaluation in terms of perinatal outcome, consumer satisfaction and the use of manpower and training resources is required.

Table 1. Responsibility for abdominal examination.

	Number of respondents	(%)
Usually carried out by midwife only	161	*(13.9)*
Usually carried out by doctor only	193	*(16.7)*
Carried out by midwife, but usually repeated by a doctor	564	*(48.7)*
Carried out alternately: by midwife at one visit and by doctor at next	79	*(6.8)*
Situation varies from one clinic to another	100	*(8.6)*
No reply	62	*(5.3)*
Total	1159	*(100)*

There is also a need for greater flexibility in the maternity care available to women at the beginning of pregnancy. Prior to the introduction of the National Health Service, the community midwife was the first point of contact in the maternity services for the majority of women. Once the National Health Service had been introduced an increasing number of general practitioners became involved in maternity care. In addition, the fact that women could book a general practitioner for delivery without payment of a fee resulted in women going to a doctor rather than to a midwife for confirmation of pregnancy. The general practitioner, not the midwife, has become the first point of contact in the maternity services for the majority of women. In recent years there has been concern about the lack of early antenatal care for those women who are not registered with a general practitioner or who are reluctant to report their pregnancy to a doctor in the first instance. The Acheson report on primary health care in inner London, indicated that in some areas up to 30 per cent of people are not registered with a general practitioner.[4] In the first Short report it was argued that it is often those women in greatest need of early antenatal care — the socially deprived and the homeless in particular — who may not receive this care owing to the present system of reporting pregnancy to a general practitioner.[5] A number of recently published reports have recommended the establishment of local antenatal clinics, staffed by midwives and health visitors, which women could attend without first seeing a general practitioner. If implemented such a system would fill a gap in the present provision of antenatal care.[5-7]

We should be striving to meet the varying needs of all childbearing women, and to do so with the effective use of resources. At present this is not the case.

References

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