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March Focus

Many years ago I wrote that GP obstetricians were an endangered species. Back then there were still many doctors with years of experience of attending women in labour, though they were already becoming scarce and many were happy to give up intrapartum care and not to have to cope with the anxiety. Since then the process has continued, accelerated by the dramatic changes in out-of-hours care in the UK. Perhaps we should not regret its passing — after all midwives have shown themselves entirely capable of providing high quality care, close to women and their homes and, when adequately supported, good low-technology intrapartum care (which, when we were campaigning for an alternative to high-tech, hospital-based care, we realised was the thing to aim for).

All, however, is not perfect, and the editorial on page 149 points out some of the difficulties: understaffing of community midwifery services; short-lived midwifery-led units; and problems of providing care from sites that are most convenient for pregnant women. Even if such problems were solved, the papers in this month's *BJGP* illustrate the need for GPs to remain involved somewhere in maternity care. Part of this comes from the way that maternity care has tended to extend its scope both earlier and later than was traditionally taught. The most recent development is in testing for haemoglobinopathy at the beginning of pregnancy.

The study on page 154 reports an inexplicable delay from presentation to screening, and presents a challenge to anyone providing care early in pregnancy. Midwives have argued for many years that such problems would be solved if women presented to them when they become pregnant, but until that happens (if it ever does) the challenge sits squarely with GPs. In any case, as the accompanying commentary on page 158 points out, with more tests for genetic problems available the genetic information will become part of the long-term record, and will 'belong' even more clearly with GPs. The study on page 161 illustrates once again that such antenatal testing can only be carried out safely and sensitively by professionals with the time and commitment to explore patients' individual understanding, and their hopes and fears. Taking account of patients' personal needs is a leitmotif of this column and the *BJGP*, so it's encouraging that NICE has, by implication, incorporated it in its definition of heavy menstrual bleeding (page 151).

Preconception services have long been advocated as one way to deal with some of these questions. They figure in the study of women with diabetes becoming pregnant on page 184. The sample was very small: three women who had experience of pre-conception counselling all reported feeling very anxious as a result. More generally the study found that, even in this group of women with diabetes few had actively planned their pregnancies, and it was often difficult to draw a clear distinction between planned and unplanned pregnancies.

Similarly the concept of maternity care has extended at the end of pregnancy, with the idea that postnatal depression can occur at any time in the year after delivery. One paper explored the feasibility of treating postnatal depression with an exercise programme (page 178). The study was planned to test recommendations based on two previous studies with small samples, but it too ran into difficulties with recruitment. It looks as if part of the problem arises from the way care is shared between health visitors and GPs, the organisation of health visitors' work, and a general reluctance to make the diagnosis in the first place (page 169). All of these studies serve to remind GPs that this contested territory is not something that we can all walk away from. The editorial on page 149 poses challenging questions for all GPs to answer to ensure that all women can have confidence in and access to prompt and effective maternity care.

This month we have for the first time started posting electronic versions of papers prior to their appearing in print, and this should become the norm in the next few months. An overdue innovation, but we're delighted to be introducing it. Finally an apology. In last month's Focus column I referred to 'well-meaning people' working on Connecting for Health. This was an ill-chosen phrase. The ones I know working on the project are doctors for whom I have the highest respect, and they deserved better than such faint praise.

David Jewell
Editor

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