

Jumping (or being pushed) from maternity care

In 1960, one-third of all births in England and Wales took place in women's homes.¹ Michael Bull, looking back in 1980 over his professional life, quoted the words of the partner he had joined when he first became a GP: 'When you look after a woman in pregnancy and deliver her, you will then have two patients for life'.² For doctors working in the more competitive world before the days of the NHS, obstetrics was a fundamental part of medical care, partly because it was a way of winning the loyalty, and the custom, of young families.

LOSS OF CONTACT

The proportion of domiciliary deliveries fell for familiar reasons: a combination of declining interest, pressure from other professionals, and the final, powerful impetus from the diluted or abandoned responsibility for out-of-hours care. Generations of GPs had already decided that hospital delivery was either safer or preferred by their patients, or that they had neither the skills nor the inclination to continue a commitment to intrapartum care. GPs argued that continuing to care for women before and after birth was enough to fulfil the professional obligation for good obstetric care.

However, with changes to working hours, the restructuring of programmes allowing less time and fewer hospital posts for GPs in training, together with the absence of any need to qualify for the obstetric list, GPs' commitment to ante- and postnatal care may also be dwindling. Combine that with midwives keen to assume overall responsibility for all obstetric care, and we may be about to witness a gradual retreat of GPs as a body from all maternity care in the UK.

LATEST RESEARCH

Three papers published in this issue of the *BJGP* suggest that such a move would be misguided. In the study on preconception care offered to pregnant women with diabetes, Mortagy and colleagues report

very mixed views from GPs, hospital doctors, and specialist diabetes nurses on the quality of such care.³ Naturally enough, those who were already involved in running dedicated clinics in specialist settings seemed to want all such patients to be referred to them early on; but there was general support for the work to take place in primary care.

While the findings revealed variable levels of commitment, there did seem to be a broad consensus that GPs should be involved to a greater or lesser degree. It would be hard to justify a major investment programme into specialist preconception clinics in the face of competing demands, and impossible in the current financial climate. For the time being, most preconception care will be within primary care.

The second paper in this issue of the *BJGP* used similar methodology to explore the views of GPs who had been involved in a study of screening for sickle cell disease and thalassaemia in early pregnancy.⁴ The main findings from this study were that offering such screening at the first pregnancy consultations increased the numbers of women screened early.⁵ In the paper by Tsianakas and colleagues, GPs reported the usual problems of time constraints and language, and some felt that offering screening was a task best assigned to midwives.⁴ Realistically, they struggled to introduce the tricky matter of screening for a genetic abnormality into a consultation whose tone is otherwise, and traditionally, so joyous and positive. They also welcomed the training they had received to participate in the study, which enabled them to help their patients understand the tests, and enhanced the overall quality of the antenatal care they were providing.

The third paper by Slade and colleagues reports an intervention intended to improve treatment of postnatal depression.⁶ With the emphasis on improving skills of health visitors, there is less direct relevance for

GPs, though it is a reminder that this is a condition often encountered in routine general practice, and reminds us of the importance of collaborative team working. The issue is discussed more fully in the accompanying editorial.⁷

These papers illustrate the familiar arguments in favour of ensuring that GPs continue to be involved in obstetric care. We bring the generalist perspective to all problems, so that we approach the care of pregnant women who have diabetes already equipped with the necessary skills, or to discussions about inherited conditions with a broad understanding and experience of clinical genetics.⁸ In an ideal world we have the personal knowledge and trusting relationships that arise from an existing long-term relationship with our patients — one that continues into the postnatal period. The paper by Slade and colleagues reports the striking, but to a GP unsurprising, finding that the personal relationships between women and their health visitors was a powerful determinant of success in treating postnatal depression.⁶

OBSTETRIC EMERGENCIES

Both the generalist perspective and trusting relationships are constant features of primary care, but there is another constant, equally important, of having the ability to deal with the unexpected. Even if midwives assume responsibility for all routine care, there will always remain the possibility of GPs being presented with obstetric emergencies. Making ourselves unable to handle such emergencies promptly and safely is, quite simply, putting women's health at risk — it's dangerous. If anyone wishes to question this assertion, they need only turn to the most recent Confidential Enquiry into Maternal and Child Health.⁹ Of 295 direct and indirect maternal deaths occurring during the period covered by the report, 66 were deemed to have some lessons for GPs. They mostly concern recognition of

thromboembolism, cerebral haemorrhage, and mental health problems.

If it is therefore unthinkable to remove ourselves altogether from maternity care, then we have to think once again of what knowledge and skills we can bring to the topic, and how they are best deployed. Such an approach is taken in a recent King's Fund report. It concludes, once again, that there is a sensible role for GPs to take throughout pregnancy, from preconception through to postnatal care.¹⁰

TRAINING

The Royal College of General Practitioners has recognised the importance of obstetrics in general practice by including in the curriculum statement for women's health a series of objectives that specifically concern the care of pregnant women, as well as associated problems such as ectopic pregnancy and trophoblastic disease.¹¹ The curriculum statement is an impressive document, but has been criticised for being excessively reductionist, focusing entirely on specifics and discounting the transferrable skills that are the strength of primary care¹² — in essence playing the specialists at their own game — but in this field the details are unavoidable.

The skills of dealing with diabetes, of counselling and testing for genetic conditions, such as thalassaemia and sickle cell disease, and of diagnosing and treating postnatal depression are all generic, which is precisely what general practice brings to obstetric practice. But the care of pregnant women requires specific knowledge and skills that belong nowhere else and can be learned nowhere else.

The trend to reduce or omit the obstetric content in postgraduate GP training programmes is therefore a worry, not in terms of job satisfaction for GPs but in terms of the overall standard of maternity care they are able to provide. Belinda Phipps (Chief Executive of the National Childbirth Trust) may be correct when, in response to the King's Fund report, she writes:

'GP knowledge on maternity issues has fallen behind current evidence and a considerable amount of retraining will be required to enable them to fulfill their role in pregnancy in relation to the health of

*the woman and the baby who have medical needs'.*¹³

Powerful bodies in this area — the Royal College of Obstetricians and Gynaecologists, The Royal College of Midwives, and the National Childbirth Trust — should be working to maintain and encourage GP involvement in maternity care and not, as is often felt by those of us who have been working in the field for any length of time, to exclude us.

VIRTUES OF GENERALISM

The value of investing in primary care is now generally accepted, owing most to the work of Barbara Starfield.¹⁴ There is also now accumulating evidence of the value of long-term personal continuity of care.¹⁵ What we don't have is evidence for, or any wider acceptance of, the value of generalism.¹⁶ In many fields the trend is in the opposite direction, towards ever greater specialisation. In medicine the trend seems inexorable, and has of late been emphasised by the development of so many disease-specific specialist nurse positions.

We must make sure that such posts work, as the nurses do in our own practices, to enhance what we do, and not, as has happened in maternity care, to deskill us. As the Confidential Enquiry into Maternal and Child Health puts it so succinctly:

'Even if they are no longer the lead carer, GPs still have a duty of care for pregnant women and should be interested in their health and well-being as they will be caring for these women, and their families, for many years to come.'

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Provenance

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