



Maternity care in general practice

General practitioners are essential providers of maternity care, particularly in rural and remote locations

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doi:10.5694/mja14.01443

Throughout the world, the role of general practitioners in maternity care is changing and being redefined. Over 10 years ago, a decline in GP-led obstetric care in North America, Europe, Australia and New Zealand was noted, and this trend appears to have continued.^{1,2} There were 481 GP obstetric proceduralists listed in the Rural Health Workforce Australia 2013 survey — 142 less than a similar survey in 2008; however, it is unclear whether these figures truly represent the total number of GP obstetricians or their skill level.³ Accurate figures for Australian births with GPs as the primary carer are difficult to find, as GP and specialist obstetric care are often combined under a heading of “private care”.⁴ In a recent Queensland-wide survey,⁵ only 11% of women reported that a GP attended their labour and birth (Yvette Miller, Queensland University of Technology, personal communication).

For many women in rural and remote areas, obstetric workforce shortages (both specialist and GP) and the closure of 50 birthing services Australia-wide between 2006 and 2011 have resulted in less than ideal maternity service provision. The need to travel outside their community to give birth causes family disruption and increases the risk of women not giving birth in hospital or giving birth in health care facilities not equipped or staffed to manage labour and birth.⁶ Further reductions in the number of GP obstetricians will exacerbate this situation.

The 2009 report of the Maternity Services Review highlighted the importance of GP obstetricians (and anaesthetists) in maintaining maternity services in rural locations. It emphasised the need for “improved access to training and ongoing support” to encourage and retain GP proceduralists.⁷ Funding is now available through the General Practitioner Procedural Training Support Program for GPs and GP registrars to upskill by completing the advanced diploma of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, which enables them to undertake caesarean sections and other forms of assisted delivery.

Training, however, is only one part of the solution. Early consolidation of newly learnt skills within a general practice environment, ongoing clinical support and mentoring, and maintenance of professional networks have been identified as strategies that improve confidence and competence and enhance further interest in procedural work.⁸ Research published in this issue of the *MJA* has shown the positive effect of a structured post-training

program on the number of practising GP obstetricians in Gippsland, Victoria. The program involves supervision in general practice, further experience in using new skills under the supervision of and mentored by specialist obstetricians, and ongoing educational activities.⁹ Other programs, such as the Rural Health West GP Obstetrics Mentoring Program and supportive placements through GP Synergy, also invest in post-training structured support for GPs to ensure they continue in procedural practice. These initiatives could be a valuable addition to the other strategies to increase and maintain the number of GPs who provide obstetric services. However, the disbanding of General Practice Education and Training and regional training providers after December 2014 may curtail the opportunities and support available for GP registrars in the future.

GP obstetricians have an advantage in providing continuity of maternity care, as they often know the woman before she becomes pregnant and care for the family on after the pregnancy and birth. Many other GPs also work with women antenatally and continue family care after the birth, even if they no longer practise intrapartum obstetrics. Almost 90% of women contact their GP to confirm their pregnancy and discuss appropriate maternity care.⁵ Shared or GP primary antenatal care, with some or all antenatal visits conducted in general practice and intrapartum care undertaken by hospital midwifery and obstetric staff, is chosen by 40%–50% of women who receive obstetric care in the public sector.^{5,10}

In addition, GPs are often responsible for postpartum care of the mother and baby after hospital discharge; 64% of women who give birth in public facilities in Queensland visit a GP by 7 days postpartum, and 87% of all women who give birth in Queensland do so by 3 months.⁵ As well as providing an opportunity to assess the physical and mental wellbeing of the mother and new baby and offer appropriate anticipatory guidance and support, these visits enable women to reconnect or connect with general practice if they have been referred elsewhere for pregnancy and intrapartum care.

The potential impact of the involvement of GPs in maternity practice should not be underestimated. The need for GP obstetricians, especially in rural and regional Australia, is unquestioned, and steps to redress the ongoing decline in numbers are underway. In contrast, the involvement of GPs in antenatal and postpartum care is often overlooked and undervalued by the community,

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other maternity providers and, sometimes, the GPs themselves. With an emphasis in general practice on chronic disease management and the ageing population, ensuring adequate services for pregnant women and young families is becoming more difficult.¹¹ With the health of future generations in mind, it is time to invest in high-quality primary care for mothers and infants by prioritising training, ongoing clinical support and specialist mentoring for GPs in all aspects of maternity care.

Competing interests: No relevant disclosures.

Provenance: Commissioned; externally peer reviewed.

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