

General practice registrars' views on maternity care in general practice in New Zealand

Hanna Preston MBChB;¹ Chrystal Jaye BA(Hons), PGDipTertT, PhD;² Dawn L Miller MBChB, PGDipGP, CertFPRH³

¹Dunedin Hospital, Dunedin, New Zealand

²Department of General Practice and Rural Health, Dunedin School of Medicine, University of Otago, Dunedin

³Department of Women's and Children's Health, Dunedin School of Medicine, University of Otago, Dunedin

ABSTRACT

INTRODUCTION: The number of general practitioners (GPs) providing maternity care in New Zealand has declined dramatically since legislative changes of the 1990s. The Ministry of Health wants GPs to provide maternity care again.

AIM: To investigate New Zealand general practice registrars' perspectives on GPs' role in maternity care; specifically, whether maternity services should be provided by GPs, registrars' preparedness to provide such services, and training opportunities available or required to achieve this.

METHODS: An anonymous online questionnaire was distributed to all registrars enrolled in The Royal New Zealand College of General Practitioners' (RNZCGP's) General Practice Education Programme (GPEP) in 2012, via their online learning platform OWL.

RESULTS: 165 of the 643 general practice registrars responded (25.7% response rate). Most (95%) believe that GPs interested and trained in maternity care should consider providing antenatal, postnatal or shared care with midwives, and 95% believe women should be able to access maternity care from their general practice. When practising as a GP, 90% would consider providing antenatal and postnatal care, 47.3% shared care, and 4.3% full pregnancy care. Professional factors including training and adequate funding were most important when considering providing maternity care as a GP.

DISCUSSION: Ninety-five percent of general practice registrars who responded to our survey believe that GPs should provide some maternity services, and about 90% would consider providing maternity care in their future practice. Addressing professional issues of training, support and funding are essential if more GPs are to participate in maternity care in New Zealand.

KEYWORDS: General practice; education; maternity care; New Zealand; rural health services

Introduction

In New Zealand, the maternity care model has changed dramatically in the past 25 years. The 1990 Nurses Amendment Act allowed midwives professional autonomy to provide maternity care without the supervision of a doctor.¹ The Lead Maternity Carer (LMC) model introduced in 1996 changed the way maternity care was provided and funded.² General practitioner obstetrician (GPO) numbers have declined dramatically since, and midwives now provide about 80% of LMC services.³ However, the number of general practitioners (GPs) providing maternity care is declining in many Western countries. Reasons

include interference of maternity care with personal lifestyle and office routine, insufficient training, difficulties retaining competency, and fear of litigation.⁴

In New Zealand, pregnant women nominate an LMC, choosing a midwife, GPO or specialist obstetrician to manage their care. Apart from early pregnancy, LMCs have clinical and budgetary responsibility for a woman's primary maternity care (antenatal, intrapartum, and postnatal). The Ministry of Health (MOH) pays the LMC a fixed fee for each module of care. If an LMC shares care of a pregnant woman with another midwife or GP, the LMC funds that care from

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CORRESPONDENCE TO: Dawn Miller

Department of Women's and Children's Health,
Dunedin School of
Medicine, PO Box 56,
Dunedin 9016,
New Zealand
dawn.miller@otago.ac.nz

the fixed fee, reducing the LMC's income and increasing their administrative costs. GPO LMCs usually need to work with another maternity care provider, especially in providing intrapartum care, as GPs often must also provide care for their general practice patients while a woman is in labour. The LMC model of care and the way it is funded makes shared care by a GP and midwife difficult.^{5,6} A small number of GPs still practise as GPOs, as LMCs, or with individual MOH contracts where maternity services are scarce. They can provide maternity and general medical care to women during pregnancy.^{5,6} In rural areas, GPs trained and experienced in maternity care are particularly valuable, including in supporting local LMC midwives and providing maternity care in remote areas with limited access to midwives.

Maternity workforce shortages have made finding an LMC difficult in some areas,^{7,8} prompting increased intake to midwifery training.⁹ While this has helped alleviate the midwifery shortage, the MOH has expressed an interest in increasing the numbers of GPs providing maternity care¹⁰ and has committed funds to training and retraining GPs.¹¹ A revitalisation of GP obstetrics requires GPs willing to practise obstetrics, adequate training and support, and a maternity funding model supportive of general practice obstetrics. However, are our future GPs interested?

Final year medical students surveyed thought GPs should provide maternity care and were interested to provide this care if practising as a GP.¹² However, we could not identify similar studies of GP registrars, our GPs of the future.

The aim of this project was to investigate GP registrars' perspectives on the provision of maternity services in New Zealand general practice, their preparedness to provide maternity care as GPs, and training available or required for GPs to provide this care.

Methods

This study surveyed registrars enrolled in the General Practice Education Programme Year 1 (GPEP1) and Years 2 and 3 (GPEP2) in 2012 throughout New Zealand. An invitation to participate was posted on the GPEP online learning

WHAT GAP THIS FILLS

What we already know: The number of general practitioners (GPs) providing maternity care in New Zealand has dropped dramatically since the model of maternity care was changed in the 1990s. The Ministry of Health would like GPs to provide maternity care and most final-year medical students support provision of maternity care in general practice.

What this study adds: This study of general practice registrars, the doctors who will be our future GPs, found that most are keen to provide maternity care services as long as there is appropriate training and ongoing education, and the model of maternity care supports shared care with midwives and is adequately funded.

platform, OWL. This Moodle platform links online teaching forums between GP registrars and educators. Prizes were offered as an incentive to participate. Three reminders were posted weekly during the four-week survey period.

The anonymous questionnaire, delivered through the online programme SurveyMonkey (www.surveymonkey.com), included questions on maternity care provision in general practice and training issues, and questions on women's health in general practice. The option of including free text was available for some questions. In this paper, we analyse the data on maternity care.

Maternity care was defined as prenatal care (preparation for pregnancy), early pregnancy care (pregnancy testing, management of early pregnancy complications), antenatal care (monitoring throughout pregnancy), intrapartum care (labour and delivery), postnatal care (care after delivery), shared care (seeing pregnant women on alternate antenatal visits to midwife visits), and full maternity care (through pregnancy, labour, delivery, postnatal care).

Descriptive analysis of quantitative data was undertaken using SurveyMonkey statistical analysis options. Using a structured deductive framework, the free-text data provided further elucidation of the statistical findings.

Ethical approval was obtained from the Department of Women's and Children's Health following University of Otago ethical approval guidelines.

Results

One hundred and sixty-five responses were submitted through SurveyMonkey (25.7% response rate). Of these, 144 were fully completed (questionnaire completion rate 87.3%). Of the 138 GPEP1 registrars, 47 responded (34.1% response rate) and 94 of the 505 GPEP2 registrars responded (18.6% response rate). Twenty-four respondents did not identify GPEP level. Younger and New Zealand European (NZE) registrars were over-represented among respondents. Female and New Zealand Māori respondents were reasonably representative of the total GPEP population, and male registrars as well as those of other ethnicities (not NZE or Māori) were under-represented (Table 1).

A total of 60.6% of respondents had postgraduate experience in obstetrics and gynaecology (O&G) or women's health. Of those, 83.1% gained experience as an O&G House Officer (junior doctor working in secondary care), 30.1% through the Postgraduate Diploma in Obstetrics and Medical Gynaecology (PGDipOMG), 18.1% through a Certificate in Women's Health, 19.3% from working at a Family Planning Clinic, and 14.5% through sexual health clinics. Some had gained experience as an O&G registrar (a more advanced junior doctor, often undertaking formal post-graduate training in O&G) or overseas.

More than 95% of respondents thought GPs who are interested and trained in maternity care should consider (response of 'yes', 'maybe') providing antenatal, postnatal or shared care with a midwife, and 29.2% answered 'yes' to trained GPs providing full maternity care (49.3% answering 'maybe'). Free-text comments included cautions about time commitments, the unpredictability of intrapartum care demands on regular general practice sessions, after-hours duties, funding, and the need for appropriate training and experience in intrapartum care.

Expectations

Providing care during labour and delivery [is] difficult... [It's] hard to cancel all your patients in order to go to the hospital. I think ideally routine antenatal and postnatal care should be shared between GP and midwives.

Others commented on the work environment and difficulty with the LMC system. Three respondents expressed interest in providing shared care with midwives. Others commented on the current culture and political environment making this difficult.

[We are] short of GPs and appointments and funding etc. makes it difficult to see this being a valid option but definitely more integrated care with midwife and GP shared care would be great!

The funding and the LMC system has put me off doing this.

When asked whether pregnant women should have the option of their GP being involved in their care, 71.1% answered 'yes' and 23.9% 'maybe'. Comments supporting GP involvement

Table 1. Demographic characteristics of respondents

| | Respondents (%) | Total GPEP (%) |
|-------------------|-----------------|----------------|
| Age group | | |
| 25–29 | 28 (17.0) | 74 (11.5) |
| 30–34 | 62 (37.6) | 207 (32.2) |
| 35–40 | 24 (14.5) | 138 (21.5) |
| 40+ | 29 (17.6) | 224 (34.8) |
| Not stated | 22 (13.3) | N/A |
| Gender* | | |
| Female | 111 (67.3) | 422 (65.6) |
| Male | 30 (18.2) | 221 (34.4) |
| Ethnicity† | | |
| NZ European | 86 (52.1) | 238 (37.0) |
| Other European | 18 (10.9) | 118 (18.4) |
| NZ Māori | 10 (6.1) | 39 (6.1) |
| Chinese | 9 (5.5) | 57 (8.9) |
| Indian | 6 (3.6) | 62 (9.6) |
| Other Asian | 7 (4.2) | 47 (7.3) |
| Other ethnicity | 14 (8.5) | 82 (12.8) |
| Not stated | 25 (15.2) | N/A |
| TOTALS | 165 | 643 |

GPEP General Practice Education Programme

* Data missing for some respondents

† Respondents could give more than one response

included continuity of care and women's interest in this option.

Would be great and many women wish this was the case.

Some comments reflected that training would be required.

This option should only be provided if the health system is reviewed to allow GPs to train/upskill in this area.

Other respondents thought the political climate could be a barrier to the revitalisation of general practice obstetrics. One stated:

'Too many cooks spoil the broth' and if we try to get involved again, it will be a political spat with LMCs.

Interest in maternity care

About 90% of respondents were interested in providing antenatal and postnatal care when practising as a GP (answering 'yes' or 'maybe'), and about 75% answered 'yes' or 'maybe' when asked about providing shared antenatal and postnatal care with a midwife. Only 4.3% wanted to provide full maternity care, 14.2% answering 'maybe' (Figure 1).

The 24 respondents considering rural practice expressed greater interest in providing all levels of maternity care, including four (17.4%) answering 'yes' to providing full maternity care (Figure 2). Rural practice was defined as having secondary care services more than one hour's drive away.

Comments reiterated the need for appropriate training, but some respondents were cautious or ambivalent about the inclusion of maternity care within the general practice scope of practice because of the increasing demands on GPs to manage long-term chronic conditions in the community.

Should not underestimate the obstetrics risks, need for training, CPD, and understand other competing health priorities in primary health care.

Apart from basic initial, first pregnancy visit, complications postnatal [should not include maternity

Figure 1. Maternity care general practice registrars would like to provide when practising as a GP (n=146)

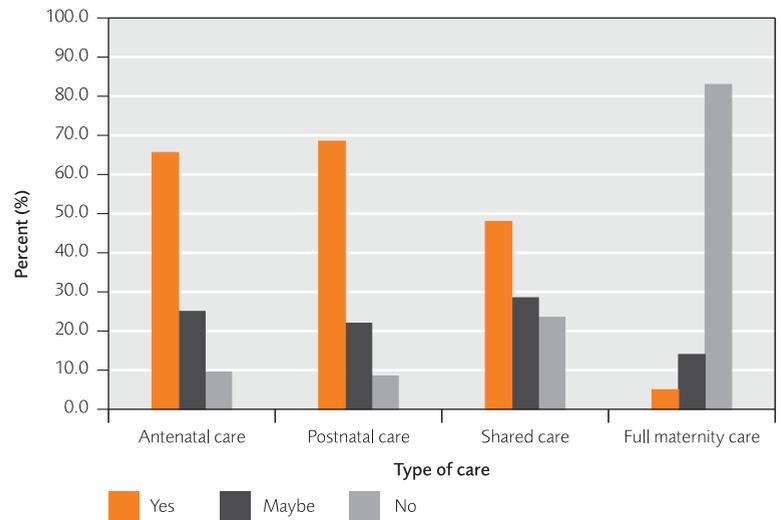
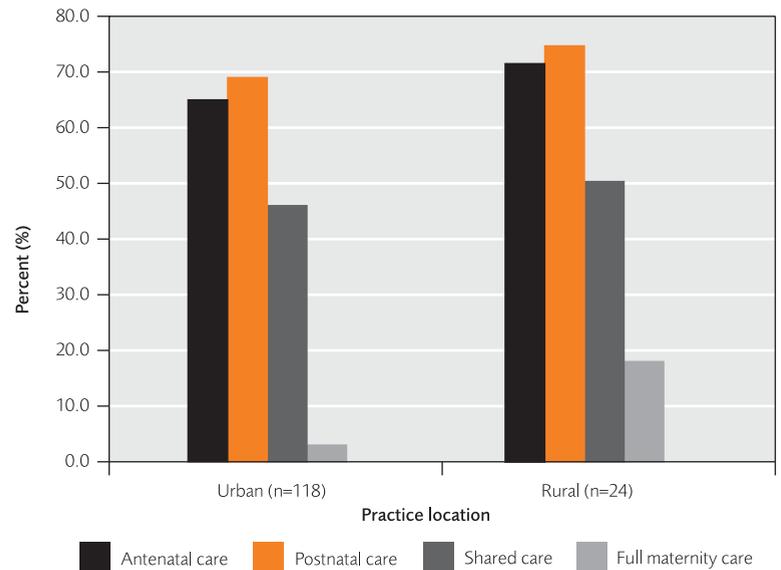


Figure 2. General practice registrars answering 'yes' to wanting to provide type of maternity care in their future practice, by intended practice location

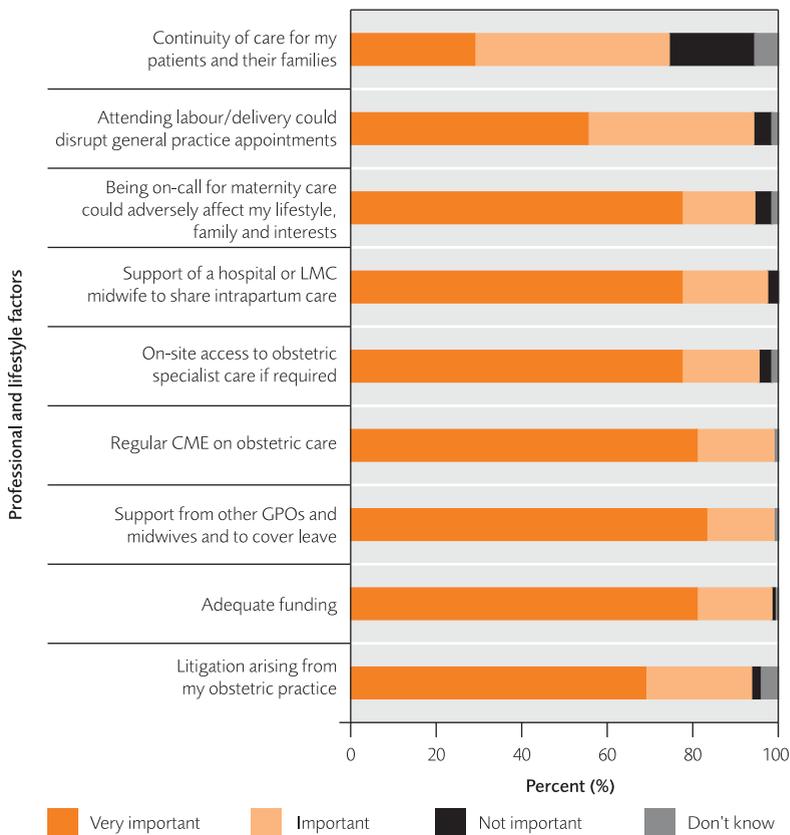


care in general practice scope of practice]. General practice becoming 'overloaded' with managing multiple conditions in the community.

Influencing factors

Respondents were asked to rate the importance of nine professional and lifestyle issues if providing full maternity care in general practice (Figure 3).

Figure 3. Importance of professional and lifestyle factors when considering providing full maternity care (n=143)



LMC Lead Maternity Carer
 CME Continuing medical education
 GPO General practitioner obstetrician

Professional practice and training issues were rated most important; effect on lifestyle, family and interests less important; and continuity of patient care least important.

Training

Most respondents considered postgraduate training necessary to provide any level of pregnancy care in general practice, with clinical training in obstetrics required for intrapartum care (Figure 4).

One respondent commented on the range of clinical experience required if training as a GPO.

I would want to spend six months working full-time in maternity care before offering full maternity care

to my patients as a GP. However this six months would need to focus on normal pregnancy, rather than obstetrics, to keep it relevant to the purpose.

Thirty respondents (18.2 %) had completed the PGDipOMG or equivalent, and 12 (7.3 %) had the Certificate in Women’s Health [or Certificate in Health Sciences (Women’s Health)].

PGDipOMG graduates thought the PGDipOMG provided reasonable or excellent preparation for antenatal/postnatal care. However, nearly half thought PGDipOMG training insufficient for practising intrapartum care (Figure 5).

It’s totally dependent on the local clinical setting. Unfortunately, there seems to be little the university can do to ‘ensure’ these clinical skills. The most challenging, of course, is normal deliveries... Great for theory, but practical skills are a separate problem.

About half of those who had not completed these postgraduate courses were considering (‘yes’ or ‘maybe’) doing so (Figure 6). Those answering ‘yes’ doubled if the six months’ hospital-based PGDipOMG clinical training was included as GPEP training time, and increased again if the course was fully funded.

Discussion

In our study, more than 95% of responding general practice registrars think maternity care should be provided in general practice and about 90% would consider providing maternity care in their own general practice. However, others thought the current LMC model and funding, or maternity care politics were disincentives, or that contemporary general practice could no longer accommodate additional demands of maternity care, and particularly intrapartum care.

Many registrars felt that women should have the option of their GP being involved in their pregnancy care. While a maternity consumer survey indicates that most women are satisfied with the maternity care they receive,⁷ the LMC model can result in women becoming isolated from their GPs during pregnancy. When a woman develops a pregnancy problem that

could be managed by her GP, the LMC tends to refer her to a funded antenatal clinic.⁵ Changes to maternity legislation now allow a pregnant woman one funded GP visit per trimester, but it would be naive to consider this integrated pregnancy care.²

A recent Health Workforce New Zealand (HWNZ) funded report proposed improved integration of care for pregnant women, utilising both midwives' and GPs' professional expertise.¹⁰ This could result in a broader range of care provided throughout pregnancy and would be consistent with the Ministry of Health's support for integrating primary care services.¹³

Registrars considering rural practice were particularly enthusiastic to provide all levels of maternity care. Only low-risk women are encouraged to birth at local primary birthing centres, including rural units, because of the lack of back-up specialist care. A 2011 New Zealand study of rural birthing centres reported that 16.6% of women developed complications requiring transfer during labour, or within six hours post-

partum, to secondary or tertiary care. Consistent with international experience, 3% of newborn babies also transferred within seven days.¹⁴ Of the 30 birthing units studied, 21 had midwifery back-up and 19 had support from local GPs, with transfers of these at-risk women and babies, suggesting that rural GPs are still involved in rural maternity care.

If the Ministry of Health wants GPs to become more involved in maternity care, serious consideration needs to be given to effective ways to support and facilitate their participation, while eliminating obstacles. Adequate professional training is essential. The PGDipOMG, formerly Diploma of Obstetrics and Gynaecology (DipObs), was originally designed for GPs planning to practise obstetrics.¹⁵ Respondents who had completed the PGDipOMG considered this course adequate or excellent preparation for providing antenatal and postnatal care, but only approximately 7% felt it provided 'excellent' preparation for intrapartum care. One issue was limited access to low-risk deliveries. GPs wanting to provide full maternity care could have specific training, such as PGDipOMG

Figure 4. GPEP registrars' views on minimum level of training needed to provide maternity care (n=144)

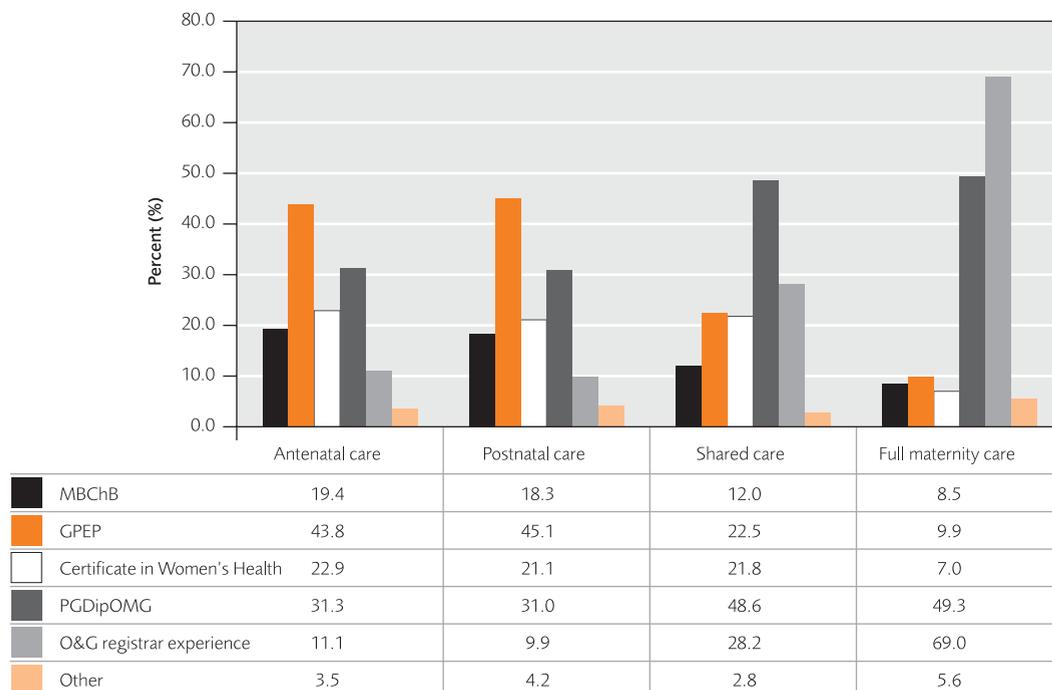
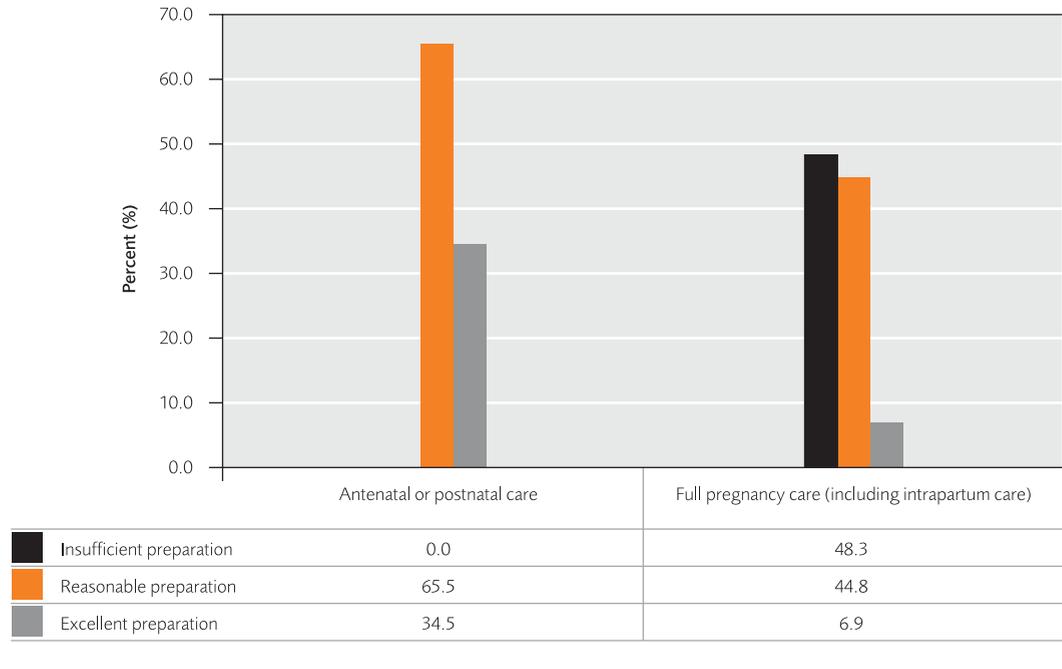


Figure 5. PGDipOMG graduates' views on adequacy of PGDipOMG as training for providing pregnancy care in general practice (n=29)



provincial hospital experience, placements with midwives, or a GPEP attachment with a GPO.

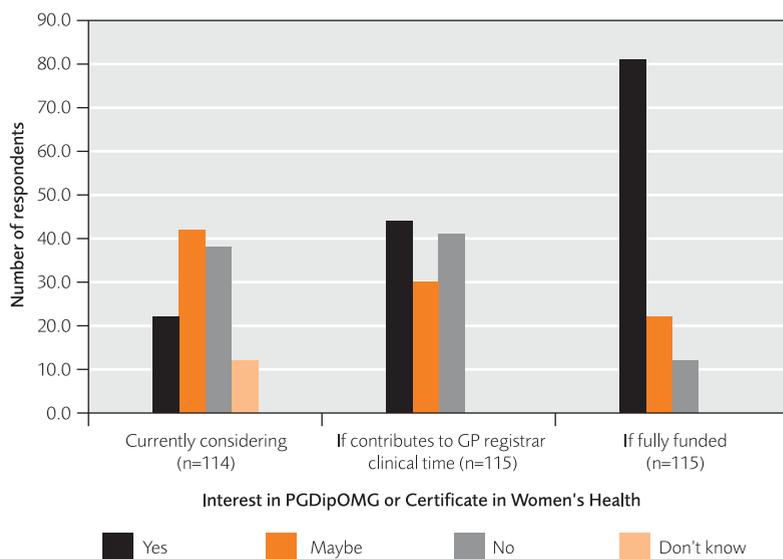
The Ministry of Health currently provides funding for GP registrars' training, and GP retraining, in maternity care.¹¹ Our study showed that

including the six-month PGDipOMG clinical placement in the three-year GPEP clinical experience would increase interest in the PGDipOMG, especially if fully funded.

Continuing medical education (CME) is another essential component of obstetric practice. The Royal Australian and New Zealand College of Obstetrics and Gynaecology (RANZCOG) postgraduate diploma course (DRCOG) now offers ongoing DRCOG CME to PGDipOMG graduates.

General practice registrars in the present study seemed less concerned about after-hours call adversely affecting lifestyle, family and interests. However, most respondents have yet to experience independent practice. An Australian study of DRCOG graduates found many did not practise obstetrics or gave up obstetrics within five years of graduation.¹⁶ Reasons for abandoning obstetrics were long working hours, on-call demands, maintaining skills, confidence, indemnity costs, and fear of litigation. Fear of litigation was relatively low in our study as New Zealand's Accident Compensation Corporation (ACC) provides cover for treatment-related injury.

Figure 6. General practice registrars' interest in undertaking the PGDipOMG or Certificate in Women's Health



The main obstacle to general practice obstetrics remains the LMC model of care. This model does not readily support shared care that is characteristic of maternity care in general practice and fails to appreciate the distinctions between skill sets and roles played by GPOs and midwives, respectively.^{4,5} If the Ministry of Health is serious about revitalising general practice obstetrics, as indicated by the resource directed into the PGDipOMG, it needs to resolve the fundamental misalignment between this initiative and the LMC model.

A major limitation of this study was the 25.7% response rate, and with over-representation of younger, NZ European females, it may not accurately represent the general practice registrar population. However, this survey captures the views of 143 of our future GPs and this lends credibility to the results. The higher response rate from GPEP1 registrars could reflect the more structured GPEP1 course and use of OWL to recruit participants. Respondents may have strong views on maternity care in general practice, and more experience in postgraduate obstetrics than non-responders.

Final comments

Although the low response rate may limit the relevance of our findings, we argue that the enthusiasm to provide maternity care in general practice expressed by most of the 143 general practice registrars studied is highly pertinent. However, the translation of this enthusiasm into action is constrained by a number of factors. These include the current maternity care funding model, the funding of postgraduate maternity training for doctors, the need for appropriate postgraduate training and ongoing CME in obstetric care, implications for the scope of general practice, and challenges facing a primary health sector struggling to meet the needs of an ageing population and increasing numbers of patients with chronic conditions. If more GPs are to be involved in obstetric care, the maternity care model needs to be compatible with general practice models of care. It must also support integration with midwifery care, shared care with midwives, and be adequately funded.

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COMPETING INTERESTS

Dawn Miller is an Academic Coordinator and tutor in the University of Otago Postgraduate Diploma in Obstetrics and Medical Gynaecology programme.