

General Practitioners providing obstetric care in New Zealand. What differentiates GPs who continue to deliver babies?

Zara Mason MBChB, FRACGP;¹ Chrys Jaye BA(Hons), PGTerT, PhD;² Dawn Miller MBChB, PGDipGP, CertFPRH¹

ABSTRACT

AIM: To identify factors that have enabled some New Zealand general practitioner obstetricians (GPOs) to continue providing maternity care and factors implicated in decisions to withdraw from maternity care.

METHOD: Semi-structured interviews and one focus group ($n = 3$) were conducted with 23 current and former GPOs. Interviews were transcribed and analysed thematically.

RESULTS: Current and former GPOs practiced maternity care because they enjoyed being involved in the birth process and delivery suite environment. Their maternity practice was framed by a philosophy of lifelong continuity of care for patients.

Legislative changes in New Zealand and barriers to shared care that resulted in many GPOs withdrawing from maternity care left remaining GPOs feeling professionally isolated; another reason for ceasing maternity care. Funding was perceived to be inadequate and on-call demands were both major disincentives to providing maternity and intrapartum care.

Current GPOs often have strong supportive local relationships with other maternity providers when compared with those no longer practicing. Local shared care arrangements enhance professional support and reduce professional isolation.

CONCLUSION: GPOs still practicing in New Zealand do so because they find maternity care highly rewarding despite their perceptions that the current maternity care model is incompatible with general practice. They have often developed local solutions that support their practice, particularly around shared care arrangements.

KEYWORDS: Obstetric; maternity; general practice

¹ Department of Women's and Children's Health, University of Otago, New Zealand

² University of Otago, Department of General Practice and Rural Health, New Zealand

Introduction

Significant decline in general practitioner (GP) maternity care provision has been observed in many western countries including New Zealand over the last 20 to 30 years.¹⁻⁴ In 1996, general practitioner obstetricians (GPOs) were involved in around 50% of New Zealand births⁵ but by 2014 only ~3% of women had a GPO involved in their maternity care.⁶ Reasons for this decline in the United States, Canada, the United Kingdom

and Australia include impact on GP lifestyle and disruption to regular practice, fear of litigation and high costs of malpractice insurance, insufficient training and difficulty maintaining skills, and poor remuneration.¹⁻⁴

During the 1990s, New Zealand introduced the Lead Maternity Carer (LMC) model of maternity care. From 1990 the *Nurses Amendment Act* allowed midwives to practice without supervision by a medical practitioner and in 1996 the Lead

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CORRESPONDENCE TO:
Dr Chrys Jaye
University of Otago,
Department of General
Practice and Rural Health,
Otago, New Zealand
chrystal.jaye@otago.ac.nz

WHAT GAP THIS FILLS

What is already known: International research shows that General Practitioners have stopped providing intrapartum care due to concerns about on-call demands, fear of litigation, insufficient training and numbers, and inadequate remuneration.

What this study adds: General Practitioners who continue to provide intrapartum care in New Zealand usually view provision of maternity care as an integral part of general practice and have often retained or developed local supportive shared care arrangements. If General Practitioners are to continue providing maternity care, legislation and funding needs to support shared maternity care.

Maternity Carer system of maternity care provision and funding was implemented. With the LMC model of care women choose one maternity carer, either a midwife, GPO, or obstetrician.⁷ LMCs have full clinical and budgetary responsibility for the primary antenatal, intrapartum and postnatal care of women giving birth in New Zealand, with specific requirements for care provision, including frequency of contacts, provision of care plans, and a budget for specific modules of care. In the 2014 maternity consumer survey 84% of women chose an LMC midwife as their maternity care provider.⁶

Access to maternity care is difficult for some women, especially in rural areas.^{6,8,9} This has led to increased midwifery training, alleviating a midwife shortage. The Ministry of Health is also keen for more GPs to provide maternity care and is funding training and retraining of GPs in obstetrics.^{10,11}

While research has been undertaken internationally to determine why primary care doctors no longer choose to provide maternity care, this is the first study to examine reasons for the decline in New Zealand. In a previous publication, we examined GPOs' perceptions of the overall impact of the current LMC model on GP participation in maternity care.¹² Few studies have examined factors associated with GPOs continuing to provide intrapartum obstetric care. In this paper we explore the personal experiences of a cohort of New Zealand GPOs and former GPOs in providing maternity care, to determine the key factors that enable some to continue to

provide maternity care, compared to GPs who have ceased maternity practice.

Methods

We conducted a qualitative study of 20 individual semi-structured phone interviews and one focus group interview ($n = 3$) over a 12-month period during 2008–09. Of the 23 participating GPs, 13 had ceased maternity practice over the previous 10 years and 10 GPs continued to provide full maternity care as GPO LMCs. The names of former and currently practicing GPOs were identified by contacting all public delivery suites and birthing units in New Zealand. The resulting lists of both current and former GPOs were then purposively sampled to achieve representation of urban and rural areas, with and without access to specialist obstetric backup. This yielded 20 potential participants, 10 current GPOs and 10 former GPOs. One current GPO and two former GPOs declined to participate, with two more failing to respond to our invitation. Four further potential participants were selected from the initial lists. The sampling strategy was revised to fill gaps in the geographical distribution of participants and to achieve saturation.

One focus group was conducted with a group of former GPOs ($n = 3$) at the outset of the research process to test the interview guide. These data are included in the analysis reported here. The interview guide included questions about the experiences of both current and former GPOs; reasons for ceasing or continuing to provide intrapartum care and their views regarding current and future maternity care services in New Zealand. All interviews were conducted by one of the authors face to face with local participants at their workplaces, and by telephone with all other participants (see Table 1).

The qualitative data analysis software program ATLAS.ti was used in conjunction with a template organising style of thematic analysis.¹³ Data were organised into themes from the interview guide and emerging from the interviews. Data were coded for individual GPs' practice location, distinguishing between urban and rural GPs and proximity to specialist care services, and whether they had ceased or continue to provide LMC care. All interview transcripts were analysed by

the authors, each of whom had responsibility for specific codes and memos. Meetings during this period confirmed an ongoing high degree of concordance among all authors.

The University of Otago Human Ethics Committee reviewed and approved the protocol for this research project.

Results

Three main themes emerged pertaining to facilitators for continuing GPO practice: motivation for providing maternity care, issues around lifestyle and work-life balance, and the logistics of providing intrapartum care in the changing maternity care landscape.

Motivation for providing maternity care and the perceived role of GPOs

Most participants described maternity care as a highlight of their general practice career. They enjoyed the continuity of care with families, teamwork with midwifery, other GPOs, and specialist obstetric colleagues, and using their intrapartum competencies. These aspects enhanced the relationships and diversity of their GP practice. All former GPOs described a sense of loss from ceasing intrapartum care provision, while current GPOs predicted a substantial change in their career satisfaction if they stopped providing maternity care.

I must say that practicing GP obstetrics has been the most enjoyable part of my professional life... I really felt the practice involving maternity care was a model for provision of family medicine. (rural former GPO)

Current GPOs described maternity care as an integral part of the 'cradle to grave' philosophy. This philosophy of continuity of care appeared to be a key motivator for continuing to provide maternity care.

I still have the philosophy that the GP is the family doctor and if you can provide prenatal, natal and postnatal care, that's what good family medicine is all about. So I have kept doing it even

Table 1. Demographic profile of participants

Demographic characteristic	Practicing GPOs (n = 10)	Former GPOs (n = 13)
Gender		
Women	4 (40%)	4 (31%)
Men	6 (60%)	9 (69%)
Age		
30–39 years	1 (10%)	0
40–49 years	2 (20%)	2 (16%)
50–59 years	5 (50%)	9 (69%)
60+ years	2 (20%)	2 (16%)
Ethnicity		
New Zealand European	8 (80%)	13 (100%)
Chinese	1 (10%)	0
Indian	1 (10%)	0
Primary medical degree		
New Zealand	8 (80%)	10 (77%)
Outside New Zealand	2 (20%)	3 (23%)
Years practicing as GPO		
<10 years	2 (20%)	0
10–19 years	2 (20%)	3 (30%)
20–30 years	6 (60%)	8 (80%)
30+ years	0	2
GP practice		
Solo practice	5 (50%)	2 (15%)
Group practice	5 (50%)	11 (85%)
Types of labour care provided		
Normal deliveries only	5 (50%)	6 (46%)
Instrumental (low forceps/ventouse/pudendal blocks)	5 (50%)	7 (54%)
Secondary obstetric care service		
Within one hour's drive of practice	6 (60%)	9 (69%)
More than one hour's drive	4 (40%)	4 (31%)

though all my colleagues have stopped because that's my philosophy. (urban practicing GPO)

Almost all participants considered GPOs had a unique role because of their longstanding relationships with patients and their families, and their ability to manage common medical problems in pregnancy. Rural participants, both current and former GPOs, talked about their role in improving both access to locally based maternity care and the safety of rural women delivering in their communities, a reason some cited to explain why they provided maternity care.

There is a difference between rural and urban. I think in an urban area there is more of an ability to call on other expertise... and so maybe GPOs in urban areas are not so necessary... (rural former GPO)

New Zealand maternity care landscape

Interprofessional relationships, teamwork and peer support

Many participants discussed the impact of teamwork and collegial relationships with fellow GPOs, midwives, and specialist obstetricians on their ability to provide maternity care. This was generally perceived by both current and former GPOs as pivotal to providing safe, enjoyable, and sustainable maternity care.

I was petrified for quite a few of my first deliveries of what would happen if something did go wrong, but felt really backed up by the fact that there were lots of much more experienced GPOs that all lived within five minutes of the hospital too and I knew they wouldn't mind if I called them. I didn't have to very often but I did call. (rural practicing GPO)

Collegial support from other GPOs was considered particularly important. Declining numbers of GPOs since the 1990s made it increasingly difficult to arrange cover for leave and the remaining GPOs experienced increasing professional isolation. Some GPOs were determined to continue practicing in the absence of local GPO colleagues. Others admitted that when their local GPO colleague(s) ceased practicing, they would most likely cease practice also.

Most GPOs described excellent working relationships with specialist obstetricians for referral and advice, and also for covering leave.

With the excellent telephonic support of the specialists in [tertiary referral centre]... one of the strengths of that was that as I trained under them and they knew me well, very often the specialists were in a position to say, 'no, no, you know what you're doing, that's going fine, carry on'. (rural practicing GPO)

Several GPOs described local arrangements that had been implemented either at a practice or District Health Board level enabling GPOs, midwives and specialists to work together. These ranged from shared care arrangements with local midwives to contracted antenatal visits and funding for emergency assistance in intrapartum care. Some of these arrangements appeared to have been successful incentives to continue providing obstetric care. It was apparent that such arrangements are highly localised. Practicing GPOs tended to work in areas of New Zealand where workable shared care arrangements existed, and asserted that they would not be able to provide maternity care without these arrangements. One former GPO stated that she ceased maternity care when the shared care funding agreement was discontinued.

Funding

While no former GPOs cited funding as their primary reason for having ceased maternity care, the low level of remuneration for LMCs was a major disincentive to continuing GPO maternity care, and this contributed to a sense of feeling undervalued in the maternity sector. Current GPOs all stated that they provided LMC care despite funding issues.

For me it was never about the money, and in the practice that I worked in it was always very clear that... it's just part of general practice, it's what we do. (rural practicing GPO)

Participants considered the current model of maternity care encouraged competition rather than interdisciplinary co-operation between midwives, GPOs, and specialist obstetricians. Despite positive working relationships with midwifery colleagues, the LMC funding system had greatly affected collegial relationships for most current GPOs. In addition to local practice and District Health Board formalised shared care and funding arrangements, current GPOs often found ways to work around the LMC funding system, entering into private arrangements with independent midwives for intrapartum support, covering leave and shared antenatal and postnatal care.

I'm pretty easy going about funding for the midwives, because I recognise that she has a very important role to play in the birth and labour process. So, I'm very happy to... negotiate a fee with them, and we've had no problem doing that over the years... having said that, it certainly takes the financial gain out of obstetrics. (urban practicing GPO)

Two of the ten practicing GPOs worked as salaried rural GPs. They both worked alongside hospital salaried midwives in their community hospital birthing units and felt that this facilitated their involvement in intrapartum care, as there was no financial disincentive to work together.

Maintaining skills and continuing medical education

Some GPOs discussed difficulty with delivery numbers and maintaining skill levels, partly because they were competing with midwives and specialist obstetricians for deliveries. This was particularly the case for GPOs still practicing in recent years.

The reality is that it's very hard to compete with midwives who say we do things naturally... and obstetricians who offer a scan every time you walk through the door, so you can see your baby growing. The GP does not appear to have that sort of facility, so it's unlikely I'm going to continue to have large numbers. (urban practicing GPO)

Others discussed how difficult it was to find suitable medical education, which was appropriate for GPO scope of practice, with many having no contact with other GPOs.

Lifestyle and the logistics of providing maternity care

The demands of maternity care on GPOs' lifestyle was identified as an issue by all study participants, specifically the demands of 24 h on call commitments and its impact on their families and work-life balance.

You are just swimming around in slosh because all the time you were going to possibly get a

call...always had to think 'have I got my phone? Will it work in that range? What gear have I got with me if I get called?' (urban former GPO)

Most former GPOs stated that while lifestyle was not their primary motivation for ceasing, it was the main reason they would not consider re-entering maternity care. Current GPOs said that although 24-h call had a major impact on their practice schedules and life outside work, local shared care arrangements were invaluable, especially in rural areas, in managing this demand.

Discussion

Motivators for continuing intrapartum obstetric care for our participants included providing continuity of care to patients, maternity teamwork, and using obstetric competencies. Providing maternity care was a highlight of participants' general practice careers. This corroborates United States research, showing that career satisfaction among family physicians is associated with providing intrapartum care.¹⁴

Unlike Canada,² the United States,³ and Australia,¹ fear of litigation was not identified as a major disincentive in our study as New Zealand health professionals work in a unique medico-legal environment. The Accident Compensation Commission is a universal, no fault accident compensation scheme for personal injury occurring in New Zealand. Medical practitioners are protected from litigation arising from medical misadventure, although are they are still liable to professional disciplinary hearings.¹⁵

Reasons for ceasing maternity care have been studied in many countries but few studies have examined factors associated with GPOs providing maternity care. Our findings suggest that a funding model for maternity care that allows shared care and accommodates GPs' other clinical commitments is a prerequisite for attracting GPs back to maternity care. A 2005 pilot project, involving family physicians in an interdisciplinary maternity centre in Ontario, Canada, found that the use of shared call arrangements in family physician-staffed, low risk maternity clinics increased physician job satisfaction and levels of patient satisfaction.¹⁶ Similarly, a cohort study

of GP trainees in the United Kingdom demonstrated that the ongoing provision of maternity care was associated with having partners within the trainee's practice also providing obstetric care.¹⁷ GPOs in our study also identified the importance of having the support of other GPOs or midwives practicing in their area – to provide support in patient care, cover for leave, and colleagues with common interests in continuing education. When that support diminished GPOs were more inclined to give up providing maternity care themselves.

Lifestyle imbalance and the impact of 24-h call on personal and family commitments is one reason for a declining GPO workforce in many countries.^{16,18} Our study participants, both practicing and former GPOs, struggled to balance 24-h call commitments, but few cited this as their primary reason for ceasing maternity care. Shared care arrangements mitigated the negative impact of 24-h on-call maternity care.

Downstream effects of diminishing caseload on clinical confidence and experience, and the lack of appropriate CME, influenced decisions to cease maternity care for some study participants, but these were not major factors. This appears similar to international studies where 20–25% of GPs have cited diminishing workload as a major reason for ceasing obstetric practice.¹⁹ A stable maternity caseload may be an important factor for continuing GPO practice.

There appears to be a delicate balance of factors influenced by local relationships between maternity care providers, individual practice arrangements, legislation and health care system factors, and the medico legal environment in which GPs work. In New Zealand, the last two decades have seen a change in the balance of factors influencing GPO involvement in maternity care, with difficulties with the LMC model of care and consequences of those changes outweighing the positives for many GPOs. Only small numbers of GPOs have been able to maintain or develop local arrangements that enable them to continue working as part of a maternity care team, to maintain a stable caseload, and to successfully balance the demands of maternity care with family and lifestyle.

We sampled ~25% of GPs still practicing as GPOs in New Zealand at the time we conducted this research. A strength of the study was the strong homogeneity evident across accounts of current and former GPOs about the issues in providing maternity care.

Conclusion

New Zealand GPOs consider many factors when deciding whether or not to continue to provide maternity care. Some of these factors, such as on-call demands, are similar to factors identified overseas. The primary finding from our research is that GPOs who have strong relationships with local maternity care providers or are able to work with other providers in shared care arrangements are more likely to continue to provide intrapartum care.

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