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Lead maternity care needs to be embedded in general practice

NO

The suggestion that lead maternity carer (LMC) care needs to be embedded into general practice requires a considered response. The *Collins Concise Dictionary* definition of 'embedded'—'to become fixed firmly and deeply in a surrounding solid mass'—does not sound like the ideal world for most women who are excited to be pregnant and looking forward to becoming a parent. Parenting opens a new world of responsibility that requires enormous amounts of decision-making and some would say courage. If a fixed surrounding is what is meant by embedded, then this would not work for community midwifery services, or indeed pregnant women and their families. If it means a fixed emphasis on general medical practice, rather than primary maternity care, then this is not helpful to primary health service either. Pregnancy is not a medical event but a fundamental life event.

On the other hand, to be integrated or 'made into a whole, to amalgamate or mix with an existing community' sounds a much healthier prospect and a better platform for developing good health habits and self-determination for a lifetime of parenthood. Integrated health services don't require a fixed abode or a 'one size fits all' approach. It requires access, collaboration, cooperation and respect between services.

Integration is a commonly used term and there has been much emphasis on 'integrating' services within the health sector. However, the focus of this integration has often been at an organisational level, rather than integrating services around the individual who is the recipient of health services. The ideal platform for all health services is that the person is in the centre of all activity and that they can make the transition from one service to another in a seamless fashion. For the New Zealand (NZ) pregnant woman and her family, this integrated woman-centred service is manifested in the role of the LMC. The LMC is the specialist organiser or navigator of care during the maternity episode, much like general practice is the navigator for access to specialist medical care for patients. For most women, the LMC will also be the provider of the primary health midwifery services, and for over 89% of women, the LMC will be a midwife.[1] This enables most women to have continuity of midwifery care from a known midwife chosen by the woman for the duration of her maternity care. The LMC (or her 'back-up') is responsible for that woman's care on a 24-hour basis. Most general practices would struggle to provide this level of coverage.

Midwifery education is the equivalent of a four-year degree programme, where the last student year is spent almost entirely apprenticed or working with experienced LMCs and hospital midwives across all settings. The first year of practice for all new graduates is a mentored one. All midwifery degrees have a strong biomedical, physiological, behavioural and evidence-informed curriculum that is provided in a cultural and

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social networking model of care. In other words, midwifery, as a specialist programme that focuses on pregnancy, childbirth and newborn care is well placed to provide primary maternity care. Midwifery-led care is also well supported by the evidence as effective and safe.[2] The New Zealand Ministry of Health recently commissioned a study that also provides strong evidence that the current model of care is successful. The study confirms that:

> New Zealand maternity services are of a high standard... In comparison with the other countries in this study, New Zealand has similar or better outcomes across a wide range of measures.[3]

The midwifery profession has long maintained that pregnant women would be advantaged if funded to access their GP for their usual medical care during the maternity timeframe (e.g. for influenza, allergies etc). This encourages medical care continuity during and following pregnancy.

The work of the midwife LMC is largely in the community and requires flexibility. The vast majority of maternity care (99.94%) covering the nine months of pregnancy and six weeks of postpartum care is provided in the woman's home and/or the midwife's clinic rooms. Clinic rooms are usually close to women's homes. In many rural areas, the midwife is often the closest health service for families, as there is no general practice service close by. The labour and birth, although hugely important, is only a small proportion (0.06%) of maternity care. The LMC midwife provides intrapartum care that is integrated with hospital (midwifery and obstetric) services. The majority of women choose to birth in a maternity facility, although there has been a consistent proportion of women (3%) choosing to birth at home with a midwife LMC.[4]

So midwifery LMC work is 'embedded' or fixed firmly in the woman's community and the LMC can link the woman to the community services she needs. Pregnancy for many women is the first time they actively engage with a health practitioner on a regular basis. Most are healthy and well. The midwife works in partnership with the woman, her partner and her family to ensure best outcomes. While most women who first register with an LMC can expect their pregnancy to be healthy and straightforward, for some their health status can change as the pregnancy develops. The LMC navigates the woman through her changing health needs, ensuring the right service is provided at the right time, in the right place. This may well be in general practice if the health issue is:

- known to her general practitioner
- one she wishes to consult them on first
- usually managed by her general practice service (e.g. asthma, essential hypertension)
- identified in the New Zealand Specialist Obstetric Referral Guidelines as a P category (general practitioner consultation).

Otherwise the most common relationship between general practice and the LMC is when the general practitioner (GP) refers the woman to the LMC and when the LMC refers the woman and her baby back to the practice at six weeks postpartum. Whilst integration at a systems level can support information sharing at points of referral and other key events, continuing communication between practitioners during this time will be entirely dependent on both the relationships between all parties, including the woman, and/or any agreed referral protocols.

The midwifery profession has long maintained that pregnant women would be advantaged if funded to access their GP for their usual medical care during the maternity timeframe (e.g. for influenza, allergies etc). This encourages medical care continuity during and following pregnancy. However, not all general practices wish to, or are able to, provide care for the pregnancy itself. Some women also prefer to go to the specialist obstetric service provided by the local district health board (DHB) with medical conditions affecting their pregnancy. Other women will require extensive input and coordination from medical expertise (e.g. obstetric, physician,

paediatric, radiography, or laboratory services). Even when this occurs, a midwife is also always involved. Women don't need to go to the general practitioner (GP) for pregnancy issues in order to access these other parallel services, as the LMC can identify the concerns and organise this for the woman. The LMC is well qualified to make these referral decisions. The outstanding feature of the New Zealand system is that a woman can have secondary care services and still keep her primary LMC to provide the primary health support (nutrition, lifestyle, foetal wellbeing, parenting preparation or motherhood/newborn information and advice) that she needs, regardless of additional need for medical services.

LMC midwives work in a variety of ways, just like GPs. Some set up clinics in conjunction with GP practices, some work from hospital rooms, some work from home and some have their own clinics (sometimes two in different places when rural). The driver for this is the women's needs. The service has been designed to enable the flexibility for the midwifery service to provide care in the many settings where women are, so the LMC can respond in the best way that meets each woman's needs (e.g. many women do not have transport or want out-of-hours appointments). The average age of midwives is 46 years and 80% of midwives have dependants. When providing 24-hour care, working for oneself and choosing your workplace is an important factor in work–life balance, retention and sustainability for the midwifery workforce.

My argument is that all providers should work in the way that provides the best care for the women seeking maternity care. Embedding it all in one place, one building or one practice over another is provider-centred and unnecessary for a community health service. If all parties recognise the role they play and work together to integrate the services around women (and their babies), maternity care will continue to meet women's needs.

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