GP obstetricians’ views of the model of maternity care in New Zealand

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Introduction

- Legislation changes in 1990s allowed midwives to care independently for pregnant women and the Lead Maternity Carer (LMC) model introduced[1]

- LMC has full clinical and budgetary responsibility a woman’s primary maternity care. Involving another LMC is funded from the fixed LMC budget for that woman’s care.[1]

  The exceptions: in rural practice and for a home birth funding is available for a second LMC to assist with labour/delivery. [1]

- If complications develop at any stage the LMC consults with and can transfer care to secondary care maternity services.[1]

- In 1996 GPs involved in about 50% of births.[2] In 2007 5% of women registered a GPO as their LMC.[3]
Aims

To explore the views of practicing GPOs and GPs who have recently ceased providing maternity care, about the LMC model of care, its impact on maternity care in general practice, and the future of maternity care in general practice in New Zealand.
Methods

- 38 practicing GPOs and many former GPOs identified through NZ birthing units.

- After purposive sampling, final participants included:
  - 10 GPOs providing full maternity care
  - 13 GPs who had recently ceased LMC practice

- 20 semi-structured interviews and one focus group (n=3) conducted by Zara Mason (August 2008 to August 2009)

- Qualitative data analysis: ATLAS.ti software programme, template organising style of thematic analysis [4].

- University of Otago Human Ethics Committee approved the project.
<table>
<thead>
<tr>
<th>Demographics</th>
<th>Practicing GPOs (n=10)</th>
<th>Former GPOs (n=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>4 (40%)</td>
<td>4 (31%)</td>
</tr>
<tr>
<td>Men</td>
<td>6 (60%)</td>
<td>9 (69%)</td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-39 years</td>
<td>1 (10%)</td>
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</tr>
<tr>
<td>40-49 years</td>
<td>2 (20%)</td>
<td>2 (15.5%)</td>
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<tr>
<td>50-59 years</td>
<td>5 (50%)</td>
<td>9 (69%)</td>
</tr>
<tr>
<td>60+ years</td>
<td>2 (20%)</td>
<td>2 (15.5%)</td>
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<tr>
<td>Ethnicity:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Zealand European</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Chinese/ Indian</td>
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<tr>
<td>Years practicing as GPO:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;10 years</td>
<td>2</td>
<td>0</td>
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<tr>
<td>10-19 years</td>
<td>2</td>
<td>3</td>
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<tr>
<td>20-30 years</td>
<td>6</td>
<td>8</td>
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<tr>
<td>30+ years</td>
<td>0</td>
<td>2</td>
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<tr>
<td>Secondary obstetric care service:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within one hour’s drive of practice</td>
<td>6 (60%)</td>
<td>9 (69%)</td>
</tr>
<tr>
<td>More than one hour’s drive from practice</td>
<td>4 (40%)</td>
<td>4 (31%)</td>
</tr>
<tr>
<td>Types of labour care provided:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal deliveries only</td>
<td>5 (50%)</td>
<td>6 (46%)</td>
</tr>
<tr>
<td>Instrumental (low forceps/ventouse/pudendal blocks)</td>
<td>5 (50%)</td>
<td>7 (54%)</td>
</tr>
</tbody>
</table>
Results

LMC model of maternity care

- The LMC model can isolate the practitioner and the care they provide
  - Many felt here is a disincentive for primary maternity care providers to work together because involving another practitioner in a woman’s care must be funded from the fixed LMC budget for that woman.
  
  - During labour and delivery they felt that the LMC should have support of another separately funded maternity care professional to assist with care, shared decision-making and support.

It’s good to be able to put things backwards and forwards (with another maternity care provider), especially when you’re tired. It’s really helpful to have a conversation about what’s going on. (Rural GPO)
In rural areas **funding is available for a second maternity practitioner on-call to assist during labour and delivery.** However one rural GP commented:

‘a lot of deliveries occur in (rural town) with only one person involved. If a second person is needed, including myself, it’s always .. an emergency call at the last minute .. I don’t think that’s a good thing. (Former rural GPO)

Most acknowledged **the stress for LMCs on call 24 hours a day, 7 days a week.** They supported LMCs working together, sharing care and sharing call.
Effect of LMC model on maternity care in general practice

Most participants reported that the LMC model of care and funding does not fit the general practice model of care in New Zealand.

They stated that to provide continuous care during labour and delivery GPOs need to work with a midwife, usually employed by the local hospital, because GPOs are also providing care for their general practice patients. The number of hospital midwives available to provide this care has dropped markedly. Without this support, providing care through labour and delivery is not workable for most GPs.
Many GPOs and former GPOs thought **LMC funding overall was inadequate for GP participation.**

- If a GPO provides intrapartum care with the help of a hospital midwife, the DHB charges the GPO half the LMC income for that care.

- Former GPOs reported a **significant increase in income after withdrawing from maternity care.**

- To continue practicing some GPOs negotiated individual shared care agreements with MOH or DHB, particularly in rural areas.
Effects of LMC Model on Pregnancy Care

- All participants expressed concern about the **difficulty and lack of choice, that pregnant women can have in accessing maternity care** in both urban and rural areas.

- For one former GPO, still providing emergency maternity care, the nearest resident midwife was 5 hours drive away. With younger GPs not training as GPOs he was concerned that this **emergency care in remote areas, from a GP experienced in maternity care, may soon not be available.**

- They described **GPOs providing maternity and general medical care to pregnant women different from, but overlapping with, care provided by midwives and obstetricians.** They felt able to deal with more issues, both medical and maternity, before considering referral.
Most participants would like to see GPs practicing maternity care in the future. However many questioned whether this was realistic.

Many commented that the changing culture of general practice, with reduced on-call, and increased expectation of work-life balance may deter younger GPs from providing maternity care.

‘It’s a perception that has changed in the last 20 years. .... It’s all to do with it being too hard, too demanding, too time consuming, not rewarding enough, too risky, .... things that I don’t agree with, but that’s the perception’ (Urban/provincial GPO)
However some reported medical students on their GP attachments and doctors doing the PGDipOMG keen to practice maternity care in general practice. But they felt this impossible with so few practicing GPOs to assist training, mentoring, and ongoing support.

Some felt the medical profession, including RNZCGP and RANZCOG, and others suggested the government, should review issues, training.

‘it is probably a matter of central people saying, “we really want to get GPs back into obstetrics”, and I reckon it wouldn’t take much.’ (Former rural GPO)
Suggested practice models:

Some GPs described shared care with a midwife as ideal, the midwife and GPO bringing their overlapping skills and experience to a woman’s care. However with the current funding model they felt midwives are unlikely to support this.

One rural GPO thought maternity care should be funded through PHOs so that each PHO could find local solutions to local issues.

‘.. what it looks like in Dannevirke might not be what it looks like in South Auckland because the communities are really different…that would give us scope to…actively seek a Maori midwife to go and do marae clinics and help to meet the patients’ needs that we are not meeting at the moment‘ (Rural GPO)

Many GPs thought rural GPs should practice maternity care, as LMC GPOs, in shared care, or in support of midwives so more women have the option of delivering safely in their local area.
The **limitations of this study** include:

• the number of GPs interviewed. However 10 of the 38 practicing GPOs identified were interviewed.

• sampled both practicing and former GPOs carefully for maternity practice access to secondary care.

• sample included more men than women reflecting the relative proportions of practicing GPOs.
Conclusions

- the LMC model of maternity care can isolate maternity practitioners
- the LMC model is an unworkable model and inadequately funded for GP participation
- participants support provision of maternity care in general practice and identify interest in this in the next generation of GPs.

Since this research was conducted, there has been a change in government in New Zealand. The new government has expressed interest to encourage GPs to provide maternity care once more. For this to be successful the model of maternity care in New Zealand and how it is funded needs to be reviewed.
Acknowledgements

Our thanks to:

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- Fran Cockerell for transcribing the interviews
- The Dunedin School of Medicine for funding the project
References

[1] Primary Maternity Services Notice Section 88. 2007
2007

[2] Ferguson W. The decline of general practitioner involvement in
maternity care and its possible consequences for maternal and

http://www.moh.govt.nz/moh.nsf

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