



Position

The Royal Australian College of General Practitioners (RACGP) recognises that general practitioners (GPs) are an integral part of providing holistic and collaborative care during all phases of the antenatal and postnatal periods. As such, GPs should be integrated into the various models of maternity care.

The role of GPs in providing maternity care encompasses:

- providing choice for the patient
- collaborative care
- preconception care
- antenatal and postnatal care
- intrapartum care for suitably qualified GPs – GP obstetricians (GPOs)
- care for patients in rural and remote communities
- care for vulnerable groups
- high-quality education, training and research in maternity care.

Background

General practice plays a central role in the provision of maternity care. With 89% of Australian females visiting a GP in the previous 12 months¹ and 51% of pregnancies unplanned,² opportunistic preconception and early pregnancy counselling and timely contraceptive advice is critically important and sits within the scope of practice for GPs.

GPs provide a number of important functions in relation to pregnancy care, regardless of whether a GP has specialised in obstetric training. The opportunities for optimising pregnancy outcomes through the provision of preconception counselling, as well as antenatal, intrapartum and postnatal care, cannot be underestimated.³ GPs can provide continuous care across the lifespan, including care for the newborn, mother, father/partner and extended family. The ongoing relationship with a GP may last long beyond the pregnancy period.

Choice for the patient

GPs can play a vital role in informing patients of the various models of maternity care available in their region, facilitating informed decisions on which model of care is best given patient preference, local models of care, geographical location and individual risk factors.

Collaborative care

The RACGP recognises the need for women to be able to make an educated choice on the provision of their maternity care. By promoting genuine collaboration with other maternity care providers including midwives, GPOs, public and private obstetricians and child health nurses, GPs can help bridge the gaps before, during and after birth for women and their families. Regardless of the model of care chosen by the woman, the RACGP recommends the development of innovative, flexible solutions to support the integration of GPs into all models of care.

Pre-pregnancy planning

A woman who is of child-bearing age and healthy at the time of conception is more likely to have a successful pregnancy and a healthy child.⁴ Identification of women contemplating pregnancy provides a window of opportunity to improve health before conception.⁴

GPs are ideally situated to provide preconception care to women. Effective prenatal counselling can assist couples to optimise their health prior to conception, and includes such factors as diet, exercise, folate and iodine supplementation, confirming that vaccinations are up to date, and enquiring into infectious disease risk and personal and family history to assess risk, including the risk of genetic conditions to determine whether further testing should be considered.³

GPs can also assess and provide advice in regard to substance use (smoking, alcohol and illicit substances), family violence, environmental exposures, chronic disease, mental health and medication risks.⁵

Antenatal and postnatal care

Antenatal care

Australian women have a variety of options for antenatal care, many of which involve their GP. Pregnancy-related problems account for 2.71% of all GP-patient encounters, and of these encounters, 89.8% are for pregnancy or antenatal care.⁶

Seventy per cent of Australian women receive public maternity care,⁷ but this usually begins in the second trimester, well after the period of embryogenesis has occurred. While the best opportunity to optimise pregnancy outcomes comes from preconception lifestyle modifications and advice, the next best opportunity comes from appropriate education and risk identification of women in the first trimester. Diagnosis and appropriate management of early pregnancy and its complications is a vital role for all GPs.

In addition, where there is a pre-existing condition or disease or one that emerges during pregnancy, the GP is well placed to work collaboratively with other members of the extended care team to manage the comorbidities.

With the reported incidence of antenatal depression at 1:10, postnatal depression 1:7 and a reported incidence of antenatal and postnatal anxiety of 1:5,⁸ GPs are best placed to screen, manage and, where required, refer for mental health issues as a matter of course both during and after pregnancy.

GPs also play a vital role in screening for intimate partner abuse, with evidence suggesting that four to nine women in every 100 pregnant women are abused.⁹ For many women, pregnancy and the postpartum period exacerbates the violence and threats within their relationship and for some, may provoke it.⁹

Irrespective of the level of training a GP has in antenatal care, all GPs should have the ability to recognise red flags in pregnancy and recommend the need for further investigation, review and/or management.³

For GPs who are part of a formal shared care arrangement, the RACGP recommends that a nationally consistent electronic pregnancy record – one fully integrated into current software systems – be introduced to enhance communication between the caregivers and to promote a team-based approach.

Intrapartum care for suitably qualified GPs – GPOs and GP anaesthetists

Procedural GPs have additional training and skills in their area of interest as well as general practice skills. GPOs can provide antenatal, intrapartum and postpartum care. Most GPOs in Australia hold the Diploma of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (DRANZCOG), inclusive of GPOs who can manage more complex deliveries, including caesarean births. GP anaesthetists (GPAs) have training enabling them to administer epidural analgesia in labour and spinal or general anaesthetics for caesarean births and emergencies. GPOs are able to manage uncomplicated vaginal births, instrumental (forceps, vacuum) births, management of intrapartum complications, caesarean births, tubal ligation, management of postpartum haemorrhage and other postpartum complications. GPOs, GPAs and skilled GPs can provide neonatal resuscitation and manage neonatal complications. Procedural GPs may work in various settings, including private general practice with admitting privileges at a local hospital, public hospital outpatient clinics, and public or private hospital inpatient settings.

Although most GPs in Australia are not directly involved in intrapartum care, GPOs provide the backbone of maternity services in rural and remote Australia. This is done in close collaboration with midwives in various models of care.

Postnatal care

The postnatal period can be a vulnerable time for women and their families as they adjust to the change that a newborn baby brings. GPs have a vital role in undertaking regular reviews during this time as well as working in effective collaboration with other health providers such as maternal and child health nurses, midwives, lactation consultants, paediatricians and obstetricians to optimise outcomes for families.³

It is critical postnatally that clinical handover back to the GP occurs at or before the time of hospital discharge. This handover allows GPs to facilitate high-quality postnatal care and to understand and anticipate the needs of the woman, her partner and her newborn. GPs can build on existing relationships with their patients and their families during this often difficult period, and to manage common neonatal concerns, as well as medical and mental health problems of the mother and other family members, should they arise. Regular, comprehensive reviews are offered at 5–10 days and six weeks, with many women, infants and their families requiring additional support over the postnatal period. In addition, these visits enable families to reconnect or connect with general practice if they have been referred elsewhere for pregnancy and intrapartum care.¹⁰

GPs provide ongoing management of medical conditions that may have developed in pregnancy, such as hypertension, diabetes and anaemia. Preventive health and lifestyle recommendations can be instituted, which can affect long-term health outcomes for women, their families and, crucially, for subsequent pregnancies.

Rural and remote

Working in rural or remote Australia offers a unique context to delivering maternity care services. Australia is a geographically and culturally diverse country and this is reflected in the varied maternity care arrangements. Women have a right to safe maternity care as close to home as possible. Maternity care in the rural and remote setting in Australia depends upon GPs, particularly procedural GPs, working in close collaboration with local midwives and other health workers. GPOs provide the bulk of the intrapartum medical workforce in rural and remote Australia, where 100% of the RA5 (Remoteness Area 5) and the majority of the RA4 obstetric workforce is provided by GPOs.¹¹ Backup from obstetric specialists in secondary and tertiary referral centres may be hundreds of kilometres away. Collegiate and positive collaboration between all of the maternity care providers is fundamental to women's and babies' safety and to the longevity of these services.

The use of telehealth has reduced the burden of travel for women in pregnancy. Where referral or transfer of women for birth is necessary, systems in place to support good communication with referring GPs and local hospital-based clinicians are essential. Financial and emotional support for women who must leave their community for maternity care must be considered.

Health workforce policy must be supportive of procedural GPs, as the loss of a GPO or GPA to a community may mean the collapse of the local maternity service. Opportunities are required for procedural GPs to learn, develop and maintain their skills in both regional and metropolitan locations. Procedural GPs require regular face-to-face and other forms of continuing medical education. Locum relief for education and leave is essential.

Training, however, is only one part of supporting procedural GPs. Identified strategies, such as consolidation of skills within a general practice environment, ongoing clinical support and mentoring, and maintenance of professional networks, improve confidence and competence and build further interest in procedural work.¹²

Caring for vulnerable groups

GPs are ideally placed to provide and negotiate patient-centred care in the social-cultural context of the patient. Identification by GPs of women who may be vulnerable during the preconception, antepartum and/or postpartum periods is essential, as these women need to be identified early and appropriately supported. Support strategies include the provision of culturally safe care, and the use of interpreters and other health workers. Groups at increased risk include Aboriginal and Torres Strait Islander women, women of refugee backgrounds, women in culturally and linguistically diverse (CALD) communities, adolescents, women with disabilities, those with chronic disease, women with mental health disorders, women in family violence environments, those in prison and those in same-sex relationships. The long-term relationship that develops between a patient and a GP lasts long beyond the end of pregnancy.

High-quality education, training and research in maternity care

Having a well-informed, skilled general practice sector is an essential component of the maternity workforce. GPs in Australia can provide a broad spectrum of care in the preconception, antenatal, intrapartum and postnatal periods, depending on the context in which they work. In 2011, the Royal Australian College of Obstetricians and Gynaecologists (RANZCOG) in conjunction with the RACGP and the Australian College of Rural and Remote Medicine (ACRRM) revised a suite of women's health qualifications available to cater for these different contexts.³ In addition to this initiative, the RACGP and ACRRM will work together to develop a training pathway for rural generalist doctors.

Regular collaboration and cross-discipline education with local referral centres and knowledge of available services is essential for good maternity care. It is essential that flexible pathways are created that provide the ability to employ, upskill and maintain the skills of the GP workforce in both urban and rural settings, using the hospital and community sectors.

The RACGP acknowledges that there are gaps in the evidence regarding the role of GPs in delivering maternity care and recognises that more Australian research is needed.

Author: RACGP Specific Interests

Review date: May 2021

References

1. Australian Institute of Health and Welfare. The health of Australia's females. Canberra: AIHW, 2017. Available at www.aihw.gov.au/reports/men-women/female-health/contents/access-health-care [Accessed 1 May 2018].
2. Marie Stopes Australia. Real choices: Women, contraception and unplanned pregnancy. Melbourne: Marie Stopes International, 2008. Available at www.mariestopes.org.au/wp-content/uploads/Real-Choices-Key-Findings.pdf [Accessed 1 May 2018].
3. The Royal Australian College of General Practitioners. PC16 – Pregnancy care contextual unit. Curriculum for Australian General Practice 2016. East Melbourne, Vic: RACGP, 2016. Available at www.racgp.org.au/Education/Curriculum/Pregnancy-care [Accessed 1 May 2018].
4. Stephenson J, Heselhurst N, Hall J, et al. Before the beginning: Nutrition and lifestyle in the preconception period and its importance for future health. *Lancet* 2018;391(10132):1830–41. doi: 10.1016/S0140-6736(18)30311-8.
5. The Royal Australian College of General Practitioners. Guidelines for preventive activities in general practice. 9th edn. East Melbourne, Vic: RACGP, 2016. Available at www.racgp.org.au/your-practice/guidelines/redbook/1-preventive-activities-prior-to-pregnancy [Accessed 1 May 2018].
6. Wong C, Gordon J, Pan Y, Henderson J, Britt H. Antenatal care in Australian general practice. *Aust Fam Physician* 2016;45(8):538–41.
7. Department of Health. Provision of maternity care. Canberra: DoH, 2011. Available at www.health.gov.au/internet/publications/publishing.nsf/Content/pacd-maternityservicesplan-toc~pacd-maternityservicesplan-chapter3 [Accessed 1 May 2018].
8. Austin MP, Highet N, Expert Working Group. Mental health care in the perinatal period: Australian clinical practice guideline. Flemington, Vic: Centre of Perinatal Excellence, 2017. Available at <http://cope.org.au/wp-content/uploads/2017/10/Final-COPE-Perinatal-Mental-Health-Guideline.pdf> [Accessed 1 May 2018].
9. The Royal Australian College of General Practitioners. Chapter 2: Intimate partner abuse: Identification and initial validation. In: Abuse and violence: Working with our patients in general practice. East Melbourne, Vic: RACGP, 2014. Available at www.racgp.org.au/your-practice/guidelines/whitebook/chapter-2-intimate-partner-abuse-identification-and-initial-validation [Accessed 1 May 2018].
10. Brodribb W. Maternity care in general practice. *Med J Aust* 2014;201(11):626–27.
11. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. 2016 activities report. East Melbourne, Vic: RANZCOG, 2017. Available at www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/RAN003-RANZCOG-ACTIVITIES-REPORT-FINAL.pdf [Accessed 14 May 2018].
12. McKenzie A, Beaton N, Hollins J, et al. Supporting GP advanced rural skills training. *Aust J Rural Health* 2013;21:41–45.

Disclaimer

The information set out in this publication is current at the date of first publication and is intended for use as a guide of a general nature only and may or may not be relevant to particular patients or circumstances. Nor is this publication exhaustive of the subject matter. It is no substitute for individual inquiry. Compliance with any recommendations does not guarantee discharge of the duty of care owed to patients. The RACGP and its employees and agents have no liability (including for negligence) to any users of the information contained in this publication.

© The Royal Australian College of General Practitioners 2018

This resource is provided under licence by the RACGP. Full terms are available at www.racgp.org.au/usage/licence

We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.