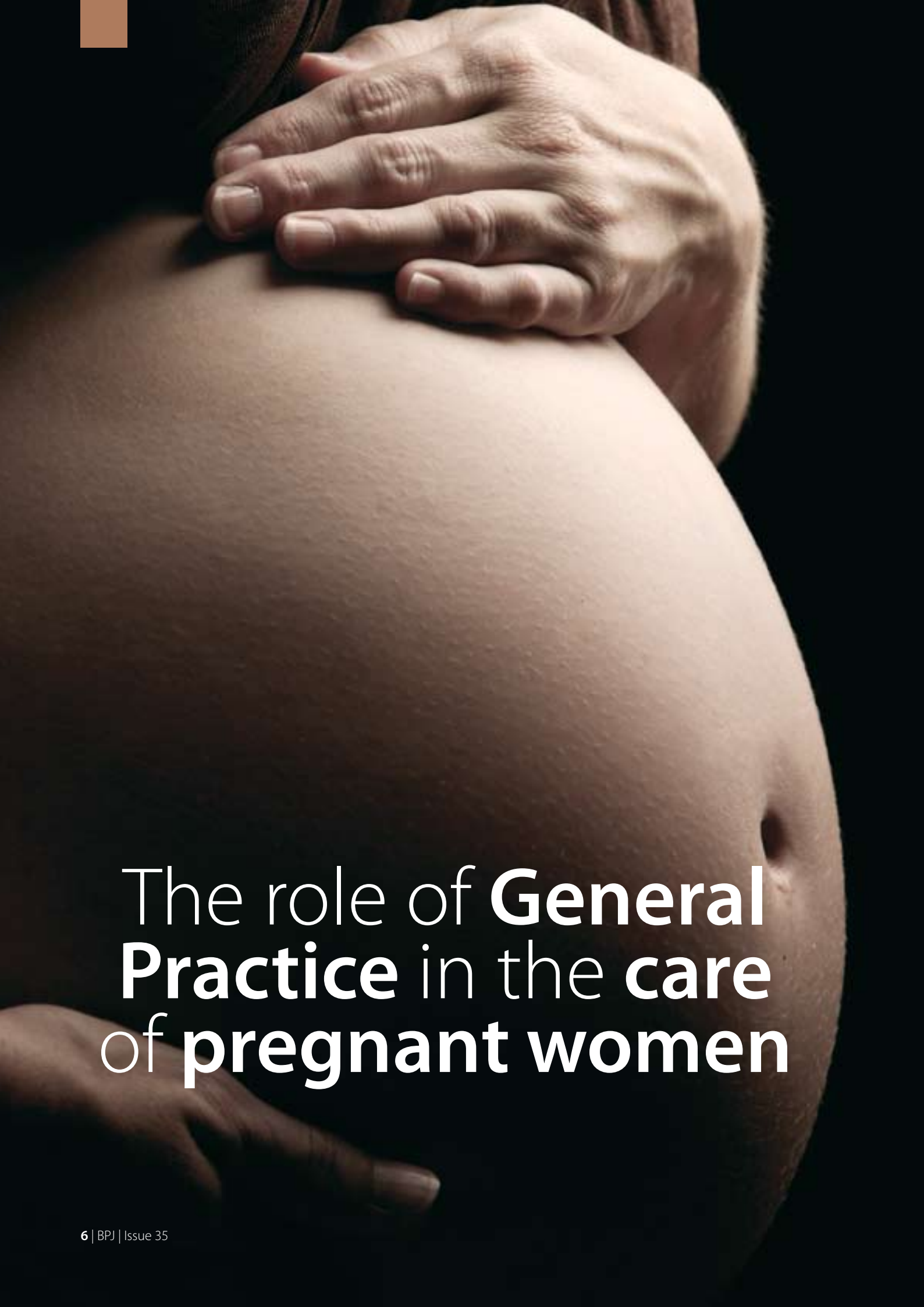

The role of **General Practice** in the **care** of **pregnant women**

THE MAJORITY OF LEAD MATERNITY CARERS (LMC) in New Zealand are now midwives. While most GPs in New Zealand no longer provide LMC services there is still a role for general practice in providing continuity of care for women with healthcare problems during pregnancy and effective pre- and post-natal care for patients in the practice.

There are both acute (see "Urinary tract infections in pregnancy", Page 20) and long-term (see "Continuing care for pregnant women with asthma", Page 15) conditions which may be managed in primary care by GPs, avoiding referral to secondary care. GPs, practice nurses and pharmacists play an important role in the provision of pre-conception information and care (see "Pre-conception care", Page 9) and often confirm the diagnosis of pregnancy for women. Primary care is also ideally placed to detect and provide early intervention for postnatal depression and to provide ongoing postnatal support to both mother and child, including information about immunisation.

Guidelines for referral during and after pregnancy

The Ministry of Health has developed guidelines to assist LMCs in appropriate referral for pregnant women who have long-term conditions or who develop acute problems during pregnancy and labour. This also includes the care of both mother and child after delivery.

The guidelines include a comprehensive list of medical and surgical conditions and guidance on the level of action required. The LMC will generally refer to an obstetrician or another specialist, e.g. psychiatrist or paediatrician. However, it is noted in the guidelines that referral to a woman's usual GP may be appropriate in some circumstances.[1]

Three referral levels are given:

Level 1 – The LMC **may recommend a specialist consultation**. Ongoing clinical responsibility should be determined by a discussion between the specialist, the LMC and the patient.

Level 2 – The LMC **must recommend a specialist consultation**. Ongoing clinical responsibility should be determined by a discussion between the specialist, the LMC and the patient.

Level 3 – The LMC **must recommend transfer of responsibility for care to a specialist**.

The referral level required will depend on the type and severity of the condition and the skills and experience of the LMC.

For example, applying these criteria to a pregnant woman with pre-existing asthma, referral recommendations would be:

Asthma severity	Referral recommendation
Mild	**Level 1:** consider recommending consultation with a specialist
Moderate (two courses of oral steroids over the last 12 months and on maintenance therapy)	**Level 2:** Recommend consultation with a specialist
Severe (hospitalisation for asthma in the last two years, history of intensive care admission, daily treatment with > 600 mcg fluticasone or > 1200 mcg budesonide or FEV1 <70% predicted in absence of acute attack)	**Level 3:** Recommend transfer of care to a specialist

In this example it may be more appropriate for a woman with mild asthma to be referred to her GP rather than an obstetrician or respiratory physician. However, care of a pregnant woman with severe asthma would require a multidisciplinary approach.

There are some conditions, such as hypertension or pre-existing diabetes, in which referral to secondary or tertiary hospital care is always recommended and it would not be appropriate for the woman to be referred solely to her GP.

Ministry of Health referral guidelines in maternity care are available from: **www.moh.govt.nz/moh.nsf/pagesmh/6257/$File/maternity-referral-guidelines-may07.pdf**

N.B. These guidelines are currently under review.

Best Practice Tip: Re-establish relationships with local providers of maternity care. One method of encouraging inter-professional collaboration and helping to ensure continuity of care is to write a "Dear LMC" letter for women early in pregnancy. This enables essential information, e.g. about long-term conditions, medication use and social aspects, to be shared. A team approach with effective communication between midwives, GPs and other healthcare providers is likely to provide best quality care.

Funding of primary maternity services in New Zealand

One of the main difficulties in encouraging General Practice to become more involved in the care of pregnant women is the fact that in most cases, these services will not be funded. The patient may be reluctant to pay for a visit to her GP when she can receive funded maternity care services elsewhere.

To qualify for funding for primary maternity services a woman must register with a LMC. Registration can occur as soon as a pregnancy is confirmed and until six weeks after delivery.

If a patient is uncertain if she is registered with a LMC, this can be confirmed by phoning the Sector Services Contact Centre on 0800 458 448

Primary maternity services include funding for:

- Lead maternity care
- Maternity non-LMC services
- Specialist medical maternity services

Maternity non-LMC services include consultations that are either additional to lead maternity care or those which are on a casual basis, e.g. woman on holiday in a different area who requires pregnancy care, pregnancy care prior to registration with a LMC. Only one non-LMC service fee can be claimed for the first trimester, per woman, per pregnancy.

Funding is not included for:

- A consultation regarding a potential pregnancy where the pregnancy test is negative
- A consultation for any medical condition unrelated to the pregnancy, including situations where the medical condition is exacerbated by pregnancy, e.g. asthma

In these situations the GP will normally charge a fee for the consultation.

For further information about maternity care services and funding in New Zealand, see Primary Maternity Services Notice 2007, Ministry of Health. Available from: **www.moh.govt.nz/moh.nsf/pagesmh/5845/$File/s88-primary-maternity-services-notice-gazetted-2007.doc**

N.B. This document is currently under review

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