Shared antenatal care – where has it been and where is it heading?

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Each year approximately 250 000 babies are born in Australia.[1] For us, as general practitioners, this means approximately 1.3 in every 100 encounters is with a woman who is about to, or has recently, given birth.[2] Building a thriving obstetric practice was once the cornerstone of a successful general practice; yet in 1998 only 17.7% of Victorian GPs provided intrapartum care.[3] This figure is likely to be much lower now, due to changes in indemnity insurance and a move by GPs to have a more satisfying personal life. Even though we are in the unique position of being able to provide care from womb to tomb, few of us continue this practice.[4]

Instead, shared care provides us with a modified (and some would say, less rewarding) form of general practice obstetrics. In this edition of our Australian Family Physician, we are presented with a variety of articles relevant to shared antenatal care. Lombardo and Golding report on the development of shared antenatal care in regional Geelong, McElduff provides an update on gestational diabetes, and Austin discusses the complexity of psychosocial risk assessment in pregnancy and the management of antenatal depression. Nel and Pashen describe some of the challenges of providing culturally responsive antenatal care to Indigenous people in one of the remotest parts of Australia, and highlight the importance of good antenatal care in reducing a totally unacceptable perinatal mortality rate.

Shared antenatal care was largely introduced to reduce the burden on overcrowded antenatal clinics. In Victoria in 1990, 2% of women giving birth participated in a shared antenatal care program;[5] in 2002 this figure is approximately 50%. These changes occurred rapidly and without rigorous evaluation.

In 1994, the Survey of Recent Mothers conducted by the Centre for the Study of Mothers' and Children's Health reported a very low level of satisfaction with shared care arrangements. Only 33% of women receiving shared care rated their antenatal care as 'very good' compared with 46% of women attending a public clinic, 72% of those attending a private obstetrician, and 80% receiving team midwifery care in a birth centre.[6]

These results shocked many hospital staff, GPs and researchers. In response, the Victorian State Government funded a review[5] in which I was involved. We surveyed Victorian public hospitals to map the shared care models available, interviewed 32 key informants at four case study sites and reviewed Medicare data. Fourteen different models of shared care were described and strengths and weaknesses elucidated. While shared care models were providing women with choice and decreasing pressure on public hospital clinics there were a number of weaknesses: fragmented care, duplication of visits and investigations, variability in the quality of care, poor coordination, and costs incurred by public hospital patients for GP visits. These weaknesses, identified in the most densely populated state of Australia, are not dissimilar from those described by Nel and Pashen in the remoteness of the Gulf country.

The outcome of the review was 17 recommendations aimed at putting the concept of sharing care into practice. We called for:

- formalised frameworks for consultation and review of shared care procedures
- development of written guidelines in consultation with GPs and divisions of general practice
- a communication strategy to engage GPs and provide the opportunity for raising concerns and contributing ideas
- increased resources committed to GP liaison positions
- written information about the models of care for women and GPs
- patient held records to assist with communication between care providers and the woman
- ongoing review and monitoring of patient outcomes within shared care programs
- written guidelines regarding accreditation of shared care providers (ideally a

process that did not require GPs to jump different hurdles at each hospital)
- the development of evidence based practice guidelines for shared care, and
- more appropriate funding models to allow these changes to be implemented.

Since the public launch of the report in August 1999 we have made much progress, as can be seen by reading the article by Lombardo and Golding. The Geelong program has:
- formalised accreditation processes
- increased communication between hospital staff and GPs
- introduced a patient held medical record
- introduced written guidelines, and protocols, and
- addressed many issues in the process of care.

Now, successful shared care programs operate in most states and territories.

Nevertheless, challenges remain. As GPs we still struggle to be heard in many tertiary hospital settings. We continue to experience conflicting emotions about the inter-professional issues that shared care raises; such as the role of midwives in routine antenatal care. During the shared care review I heard many comments expressed by GPs and midwives alike that they desired a better working relationship, and would value more respect for their role from the 'other' profession. These concerns are voiced, yet again, by Lombardo and Golding. Devising successful inter-professional working relationships should be high on the agenda of all those involved with the coordination and direction of shared care programs.

An exciting challenge is the introduction of evidence based practice. In Victoria, GPs will be aware of the Three Centres Consensus Guidelines on Antenatal Care[7] (www.health.vic.gov.au/maternitycare) and the Guidelines for Shared Maternity Care[8] Affiliates (www.health.vic.gov.au/maternitycare). These guidelines are significant in that for the first time the three major tertiary maternity hospitals have cooperated to formulate guidelines for practice. General practitioners have been involved to varying degrees in both of these projects. Reviewing these guidelines, one cannot avoid being struck by the amount of work involved in compiling them, nor by the amount of time they will take to put into practice!

Indeed, time is something that modern shared maternity care is increasingly demanding. The number and timing of antenatal visits, model of care decisions, prenatal screening for genetic abnormalities, routine antenatal screening, counselling for HIV testing and the delivery of smoking cessation programs for pregnant women are very time consuming to implement into routine practice. Austin also suggests that we use a written antenatal psychosocial risk questionnaire. The use of such screening tools, while appealing, should be tested within randomised trials before implemented into routine practice.

Shared care provides GPs with a valuable role in maternity care. The formalisation of programs has seen the re-entry of GPs into maternity units and policy arenas. We have an important role to play, and over the next decade we should ensure that the principles and strengths of general practice are firmly embedded within shared care programs.

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