On the threshold

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In Thasus, the wife of Philinus … on the fourteenth day after delivery was seized with fever attended with rigor; was pained at first in the cardiac region of the stomach and the right hypochondrium.[1]

For much of human history, pregnancy and childbirth were too closely associated with the suffering, ill health and death of mother and infant. The causes were (and still are in developing countries) infection, haemorrhage, malnutrition and hypertension.

Infant and maternal mortality in Australia have been low for many years.[2] Successive medical breakthroughs – disinfection and sanitation (1840s), antibiotics (1930s), epidural anaesthetics (1940s), synthetic oxytocin and ergotamine (1950s), the oral contraceptive pill (1960s), electronic fetal monitoring (1960s) and obstetric ultrasonography (1970s) – have also produced a revolution of thought and practice.

Today, antenatal services in Australia are accessible and available, and this month's BEACH study[3] suggests that pregnant women are generally well cared for. Providing perinatal care can be one of the most enjoyable aspects of general practice and a welcome break from treating chronic disease.

Much like our ancestors, we conceptualise pregnancy and childbirth as a transitional state. Women are 'on the threshold' between two stable identities and the future is unknown. These concepts arise from our self-awareness and ability to interact with each other and our surroundings in complex ways. Pregnancy may mark a transition from non-parent to mother, terms rich in individual and cultural meaning. An idealised view of the path from pregnancy to motherhood contrasts with the uncertainty of the outcome – the pregnancy may be unwanted or end in a miscarriage, there may be fetal anomalies or maternal illness, relationships can become strained, and financial pressures come to a head.

It is not surprising that, for antenatal care, women consult general practitioners (GPs) they have approached before.[3] Unlike midwives and obstetricians, only the GP provides healthcare for the woman as she moves from non-pregnant to pregnant to mother. Women are often more motivated to make positive lifestyle changes in pregnancy.[4] This is an opportunity for GPs to provide clear and brief nutritional information[5] to ensure immediate and long-term health gains for the mother and infant.

Men whose partners are pregnant are also in transition: the changes are not physical, but these men are also expectant, in uncertainty and moving towards fatherhood. Recognising this, men are welcomed in birthing rooms, and employers provide paternity leave. However, in contrast to medical care of women during the perinatal period, clear structures for expectant fathers is lacking in most contemporary general practice. In his focus article, Roberts suggests that GPs could have an ideal opportunity to engage men and improve their wellbeing and that of their children.[6]

Breastfeeding has a fascinating history. Carl Linnaeus initially classified humans as Quadrupedia, four-limbed animals. He later moved us to a new class, Mammalia, animals with milk-producing nipples, identifying our species by the female capacity to breastfeed. Australian women readily initiate breastfeeding (96%) but fewer sustain it at four months (39%).[7] Continuing breastfeeding is not always easy, and GPs are well placed to offer advice.[8] A woman's social environment can also influence her capacity to breastfeed. As women return to work, breast pumps, family support and childcare become crucial.

The perinatal period in Australia is, thankfully, safer because of historical breakthroughs and current sound obstetric care. It remains a time of rapid physical and psychosocial change as identities are recast and relationships altered. GPs are trusted health providers in the perinatal period, and have an important opportunity to help families consider positive lifestyle changes and choices that may produce a lifetime of benefit.

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