Integration of general-practitioner and specialist antenatal care

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SUMMARY. Despite the growing role of specialist obstetricians in intranatal care the importance of the general practitioner's role, especially in antenatal and postnatal care, is being increasingly recognized. We describe a new way of sharing care which involves the consultant obstetrician attending antenatal sessions at fortnightly intervals in the practice. In addition the antenatal record is retained by the patient herself who brings it to all attendances, both in the practice and at the hospital.

We analysed the results of this arrangement and compared them with a controlled series of hospital patients and found some advantages for shared care arrangements including, in particular, a reduction in the number of different doctors seen by patients, a big reduction in the number of patients who were seen by more than three doctors, and an increase in the breast feeding rate at the time of discharge from hospital.

Introduction

OBSTETRICS has undergone many important changes in the recent past, one of which has been the marked increase in the percentage of hospital confinements. This has inevitably brought into focus the question of the changing role of the general practitioner in the management of pregnancy (Elstein *et al.*, 1975; Wilkes *et al.*, 1975). When considering the organization of obstetric services, great emphasis has been placed on the management of labour. However, the care of a woman during her pregnancy involves more than concern for the actual confinement. The manner in which an expectant mother is prepared for childbirth both physically and psychologically may well be relevant to how she will cope with the delivery and adapt to her new role as mother. The antenatal and postnatal stages of pregnancy, and the delivery itself, form a natural continuum and this should be reflected in their management.

While intranatal care has increasingly become the responsibility of the specialist obstetrician, it is widely accepted that the general practitioner has an important role to play in antenatal and postnatal care (RCGP, 1968; Lloyd, 1975). If the patient is to receive the greatest benefit it is important that true integration between the primary and secondary health care services is achieved (General Medical Services Committee, 1977).

Integrated antenatal care

The essential nature of such a partnership is that it enables individuals to achieve particular objectives by working together which they could less easily or completely achieve independently. For it to be successful, a number of ingredients have to be present.

First, there is the need to establish common objectives for care: for example, regular clinical care should be provided by professionals, suitably trained and orientated to the needs of their patients; the care should be acceptable to and made use of by the patients; there should be a continuing personal relationship between the patient and her professional adviser throughout the pregnancy; and the patient and her husband should be provided during the pregnancy with appropriate instruction on preparation for childbirth and parenthood.

Secondly, there is the need to identify the specific characteristics of members of the partnership as determined by the setting in which they work so that each can undertake the roles for which they are particularly suited.

Antenatal care in hospital and general practice has at present distinctive, and in many ways, contrasting

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Table 1. Characteristics of antenatal care provided in different settings.

General practice	*Hospital*
Familiar surroundings	Unfamiliar surroundings
Likely to be easily accessible	Likely to be further from the home
Likely to have a short waiting time	Likely to have longer waiting time
Patient will usually see a doctor who is well known to her	Patient will see several doctors and midwives
A doctor/patient relationship will already be established at the onset of pregnancy and will continue after its completion	No doctor/patient relationship will exist at the onset of pregnancy and that which is established will be solely for the duration of the pregnancy
A relationship can be established with other members of the team (the health visitor) who will later have responsibility for the continuing care of mother and baby	No contact can be established with those who will have responsibility later for the continuing care of mother and baby
The general practitioner/obstetrician is also responsible for the general care of mother and baby	The obstetrician has no responsibility for the general care of the patient
The doctor is likely to be aware of the social background of the patient	The doctor will not usually be aware of the social background of the patient
The doctor will usually be aware of, and actively concerned with, the needs of the patient's family	The doctor will not be concerned with, or usually be aware of, the needs of the patient's family

characteristics which have been summarized (Zander *et al.*, 1978; Table 1).

Thirdly, there is the need to establish a satisfactory organization so that optimal co-operation and communication between the partners is achieved.

Shared antenatal care

The concept of shared antenatal care has received general acceptance and is widely practised. The way in which it is undertaken varies considerably but usually the patient attends her general practitioner for the early part of her pregnancy and then at a later date (often between 28 and 34 weeks) she transfers to the hospital for the remainder of her care. Although this system of management is satisfactory from many standpoints, it does not justify the term 'integrated care' as judged by the above criteria. Thus, the care received by the patient will be fragmented; there is little contact between the doctors and therefore little opportunity for establishing mutual agreement over the objectives of care. The practitioner is relieved of the care of his patient at an important stage in her pregnancy, and the obstetrician is expected to be responsible for the confinement of a patient of whom he has seen little during the preceding months.

Attempts are being made to overcome these deficiencies: some general practitioners provide care for their patients within the hospital and a more recent trend is for obstetricians to come out into the community (Matthews *et al.*, 1975). In the belief that this approach has certain specific advantages, the following form of antenatal care has been developed between the Department of Obstetrics at St Thomas' Hospital and the partners of a group practice.

Practice arrangements for antenatal care

The practice has 8,500 registered patients and has approximately 60 deliveries per year. Maternity care is provided by four practitioners at weekly antenatal sessions attended by the practice health visitor, district midwife, and dietitian. The obstetrician attends the sessions at fortnightly intervals.

The patient is seen by the general practitioner and the health visitor at an initial booking appointment at which the hospital obstetric record is completed. This is then given to the patient, who is asked to bring it with her at all subsequent visits and take it to the hospital when admitted in labour. A single card containing important information, such as blood group and special obstetric factors, is filed for each patient and left on the labour ward in case the obstetric record is not produced by the patient.

At the next visit, the patient is seen both by her general practitioner and the obstetrician and a general plan of management for the pregnancy is established. This includes identifying any particular problems, social or mechanical, which may be present, the pattern of care to be carried out, the wishes of the patient and her husband about his presence at the time of delivery, and the duration of her stay in hospital after delivery. She then continues to be seen by her own doctor throughout

Table 2. Results of care of first 60 patients seen in a group practice compared with a control group of hospital patients matched for age, sex, parity, social class, and country of origin.

Factors considered	Group practice	Hospital antenatal clinic
Administrative factors		
Total number of patients	60	60
Mean number of doctors seen	2.6	5.4
Number of patients seen by more than three doctors	8	46
Mean number of times seen by consultant	2.8	4.2
Mean time in minutes patients spent in clinic	29	44
Mean number of visits to the clinic during pregnancy	10.9	11.52
Number of patients missing antenatal examinations	1	10
Number of patients missing postnatal examinations	1	14
Obstetric factors		
Delivery		
Spontaneous vertex delivery	41	41
Breech delivery	2	2
Caesarean section	5	8
Artificial rupture of membranes	24	31
Forceps delivery	12	9
Stillbirths	2	0
Neonatal deaths	0	1
Birth weight in kg		
Mean	3.3	3.3
Under 2 kgs	3	3
Breast fed at time of discharge from hospital	26	19

the pregnancy, and the advice of the obstetrician is sought when the need arises.

The patient is seen by the dietitian or health visitor with or without the doctor whenever it seems appropriate.

After delivery, the patient returns to her general practitioner for her postnatal examination.

Results

An analysis of the results of care of the first 60 patients has been made and compared with a control group of hospital patients matched for age, parity, social class, and country of origin attending the professorial obstetric unit during the same period (Table 2).

The results show that the 'combined clinic' compared favourably with the hospital clinic. Only one patient missed her antenatal appointment compared with ten in the hospital group. As expected, few individual patients saw more than three doctors in the practice whereas 77 per cent of those in the hospital group did so. There was also a difference in the amount of time that the patients spent in attending for their antenatal visits which favoured the combined clinic.

The results of labour were essentially similar, but there was some difference in the number of breast-feeding mothers in the two groups. Only one mother from the practice missed her postnatal appointment compared with 14 in the control group, but it is not possible to ascertain whether the hospital patients attended their general practitioner instead of the hospital.

The need to have the patient's record available at every antenatal clinic and at the time of her confinement led to the innovation of making each mother responsible for keeping her own full obstetric folder. This resulted in positive benefits. The patients were exceedingly reliable in producing their records whenever required. Fears that the record would often be missing were unfounded. In fact, the patient-held records were more readily available than those kept in the hospital, largely due to the fact that it was difficult for these to be obtained when the patient was admitted in labour during the night. Only one mother attending the combined clinic arrived in labour without her record; her husband produced this shortly afterwards.

The psychological rather than administrative consequences of giving the patients their records increased the interest shown by the mothers in what was contained in the records and this was often used as the basis for explanation and discussion. On two occasions incorrect entries were brought to the attention of the doctor by the patient!

The greatest benefits to be derived from this form of care cannot, however, be easily quantified. The patients

were seen in familiar surroundings by a doctor and other professionals in the practice with whom they already had an established relationship and who continued to provide care for them and the baby following the delivery. The practitioners were able to provide antenatal care for the whole of each patient's pregnancy and were given the support and specialist knowledge to perform this function responsibly.

An added benefit was the opportunity afforded the general practitioners to discuss other problems, both obstetric and gynaecological, with the specialist and thereby often avoid the need to refer patients to the outpatient department, as well as reduce the comparative clinical isolation in which much general practice is undertaken. If such an arrangement is to have general applicability, it must be shown to be feasible in terms of the time it demands of the specialist. In this case, the obstetrician was able to monitor the antenatal care of all the patients in the practice by attending for about one and a half hours each fortnight.

Discussion

It may well be questioned whether the developments described which work successfully in a practice within 15 minutes walking distance of a teaching hospital can be developed in practices further afield. One measure of the success of the scheme has in fact been that it has subsequently been adopted in four other practices situated between 15 and 30 minutes driving time through London traffic away from the teaching hospital. Clearly it is not possible to generalize about rural areas, but it is in the urban centres that the greatest anxiety exists concerning integrated care.

Conclusion

By organizing antenatal care in this way, the general practitioner and the specialist have both been able to fulfil the role for which they are particularly suited.

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