



## **The few: New Zealand's diminishing number of rural GPs providing maternity services**

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Recently, the Royal New Zealand College of General Practitioners (RNZCGP) calculated there were 54 general practitioner obstetricians (GPOs) still providing intrapartum care within New Zealand's maternity system.<sup>1</sup> To many, including the author, this came as a surprise.

For the last few years, estimates have always put the number somewhere between 10 and 20 with the inevitable caveat that many of those left had given firm indications they too would stop in the near future. Although 54 is still a pitifully small number (and, predictably, soon to reduce to 52), the vital part they play in delivering maternity care, particularly in rural areas, must be recognised. Questions again need to be asked about whether New Zealand's maternity system is in any position to let this once proud cornerstone disappear altogether.

Before this statement is dismissed as misty-eyed nostalgia, a few facts need to be considered:

- Of the 55,000 women who give birth annually, nearly a third live in rural areas.<sup>2</sup>
- Many rural non-GPO GPs are continuing to experience emergency obstetric situations where action is required immediately to either effect an immediate delivery or stabilise a clinical event prior to transportation.

Rural GPs caught in these situations are often able to manage because of their previous experience in delivering obstetric care—but within a decade, all of this knowledge will be gone and no expertise will be available to attend these often perilous events.

These situations are occurring because the:

- Woman's lead maternity carer (LMC) is genuinely unavailable;
- LMC lives in another (larger) town
- LMC does not have the secondary care skills required for such emergencies.

In contrast to GPs, LMC midwives cannot survive in many smaller locations simply because there is not enough work for them. Also, LMC midwives have been reluctant to take on women with medical problems who will inevitably require base hospital delivery.

Some enlightened district health boards (DHBs) have recognised these problems and are paying GPs to look after their antenatal patients in a shared care arrangement with hospital maternity services. Sadly, however, many

more DHBs continue to struggle with their current lack of understanding of what is required in primary care.

- There is a workforce crisis among New Zealand's provincial hospitals where there are shortages of obstetricians, anaesthetists, and paediatricians.<sup>3,4</sup> There are now many provincial centres (e.g. Wanganui, Greymouth, Invercargill, Masterton, Gisborne) where at best specialist cover is less than ideal and at worst is imminently threatening closure of secondary care maternity unit services. Are rural women really prepared to accept this previously unthinkable situation?

Many of the remaining LMC GPOs work in areas distant from secondary services, or where obstetricians are already in short supply. Despite Section 88 payment rules discriminating against them for doing so, they continue to look after their own patients—however it is in their role of providing elements of secondary care to other LMCs' patients where they are of irreplaceable value to a local service.

Because of this availability, birthing women have more confidence in the service and are more willing to use it. Queenstown is a classic example of what can be achieved with some local expertise and what is not achieved when that expertise is absent. In 1990, there were over 100 deliveries performed locally and in 2003 only 31 deliveries were performed.<sup>2</sup> Given the continuing population explosion in this area, if the 1990 conditions were rekindled, the annual local birthing rate would be well over 200.

Evidence has always supported women birthing in their own communities, as opposed to travelling either acutely or electively to a distant major centre.<sup>5</sup> Ironically, the evidence even includes studies from New Zealand,<sup>6</sup> but most of it comes from Canada,<sup>7</sup> and Australia<sup>8</sup> where the problems of providing rural and provincial obstetric services have been similar to ours.

In response to this research, these first world health systems have (over the last 5 years) embarked on programmes to upskill generalists in provincial areas giving them sufficient skills to perform instrument-assisted deliveries, caesarean sections, and neonatal and maternal emergency care.<sup>9,10</sup>

Of greater importance, however, is the acquisition and maintenance of decision skills around referral to base hospitals these generalists bring to provincial and rural maternity units. Research again has determined that while peripheral units that have access to these sorts of skills thrive and prosper, "high outflow" units, where there is not good support by the local population, wither and die.<sup>5</sup>

Work is currently underway in New Zealand to develop a vocational training programme that will result in specialist recognition for rural hospital doctors. So far, there has been no suggestion of including a maternity care skill set in the training programme. Clearly, this needs to happen.

But of even more urgency is the need for our health system to recognise and reverse the neglect it has shown towards the provision of maternity services in rural and provincial areas compared with other countries. This neglect has resulted in needless disruption to young couples' lives, unwarranted cascades of intervention, and (on rare occasions) the death of a neonate.

This change in attitude has to begin with abandoning the deliberate handicapping of GPOs through the Section 88 framework. Instead, these 52 GPOs, who have battled for a decade against bureaucratic indifference and the anti-doctor mindset of our health system, need to be congratulated and encouraged to continue.

The best encouragement of all for the Churchillian few would be the development of a new framework that would inspire and encourage doctors in training to pursue a career that includes provision of primary maternity care, the acquisition of a few technical skills that until now have been considered the preserve of secondary care, and the ability to know when to refer.

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