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PRIMARY COLOUR

Helen Salisbury: Holding on to what makes general practice special

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Until August this year I was able to offer shared care to antenatal patients and saw them regularly, taking turns with the midwife. My role would begin with those careful, neutral questions in response to the news of pregnancy (“And how do you feel about that?”) and would carry on through to the expectant final weeks. If problems arose obstetric specialists would become involved, but otherwise this was part of my job as a generalist.

There are good reasons for taking antenatal care away from GPs, and our part of the country is the last to give up this area of work. With fewer registrars spending any of their training in obstetric posts and a lack of ongoing training or updating, our local medical committee was advised by medical indemnity providers that it would be increasingly difficult to defend GPs doing this work if anything went wrong. Indeed, they’re likely to withdraw cover for GPs undertaking antenatal care in the near future.

So, I understand that it’s a sensible move. If GPs don’t have the skills to care safely for pregnant women, we should hand this work over to people who do. As we’re clearly busy enough with the many other patients who need our attention, very few GPs will complain about the loss.

But a part of me mourns it. We may be less needed at the initial stage now that women can find the advice they need online before their first midwife appointment at 8-10 weeks—what vitamins to take and not to take, which foods to avoid, and how to quit smoking for the sake of their baby. However, information is not the only—or even the main—reason a woman visits her GP when she learns that she’s pregnant. We’re often the first person she tells, a neutral space in which to explore surprise, excitement, or ambivalence. It can be the start of a relationship between doctor and patient, and between doctor and family, that lasts for many years.

Some women bloom in pregnancy, but for others it’s a time of anxiety, relationship difficulties, and physical discomfort. I hope that we’ll be successful in sharing care with our local midwives who will now build these relationships instead of us, handing over any worries about the patient to us after delivery. I worry that, although I won’t be providing routine antenatal care, I’ll still see pregnant women when they come with apparently unconnected symptoms, and I’ll gradually become less skilled at knowing when to reassure about a pregnancy and when to be concerned.

I can imagine my colleagues of a generation ago bemoaning the demise of GP home deliveries—something we’d regard as unacceptably risky today—and I realise that we must all adapt to changing times. However, one of the joys of general practice is caring for patients from birth to death, and at all points in between. We’re not just there for when things go wrong but also to keep them going right, through all expected stages of life.

Our final role with a patient is to care for them as they are dying. I can’t help wondering if this will be the next area of our work to disappear.

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