

Collaboration with a midwife in the care of a pregnant patient with recurrent genital herpes simplex virus

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Family medicine continues to evolve as a team-oriented field of practice. Collaborative primary care in Canada involves family doctors working with midwives, dietitians, pharmacists, physiotherapists, social workers, nurses, chiropractors, and other allied health professionals. As the involvement of various care providers in collaborative care grows, family doctors must learn to adapt to shifting roles and responsibilities. At times, family doctors might find themselves playing the role of a consultant. In such cases, attention must be given to ensuring boundaries of care are well delineated and interdisciplinary communication is clear.

Case

A 33-year-old woman, rostered as a patient to our family health team, presented to the clinic at 37 weeks and 5 days' gestation requesting antivirals. She had not previously been seen by our team for her pregnancy. Although we provide prenatal, intrapartum, and postpartum care, she chose to be followed by a midwife for her pregnancy.

Upon review of the presenting concern we noted that earlier in the pregnancy the midwife had ordered serial prenatal ultrasounds, copied to our clinic, to follow a low-lying placenta until its edge was more than 2 cm clear of the cervical os. The patient told us she had also required assessment in the obstetric triage several weeks earlier for cramping, which was found to be benign. When she saw us she reported that she was feeling well and that her recent vaginal swab test results were positive for group B streptococcus. She explained that she had chosen to be followed by a midwife because she believed that with that path there might be less likelihood of surgical intervention at the time of delivery.

The patient returned to our care at the request of her midwife owing to a history of genital herpes and plans for a vaginal birth. The patient reported 2 previous known outbreaks of vaginal herpes lesions: once when she contracted the disease 12 years ago and again after giving birth to her first child 3 years ago. She reported no current symptoms of vaginal herpes or prodromal symptoms. She said that she had not yet been examined vaginally during the pregnancy.

EDITOR'S KEY POINTS

- Collaborative care involves family physicians working with various allied health care providers, including midwives. Collaboration with midwives can be enhanced by involving midwives in interprofessional teaching, meetings, and care teams, as well as through developing better standards of communication between physicians and midwives.
- Communication between family physicians and midwives who share care of patients might be strengthened through letters that clearly describe care plans, outline active pregnancy issues, and delineate the roles expected of the midwife and the family doctor.
- Pregnant women with recurrent genital herpes should be offered prophylactic acyclovir or valacyclovir at 36 weeks' gestation and through to delivery as per the current Society of Obstetricians and Gynaecologists of Canada guidelines.

POINTS DE REPÈRE DU RÉDACTEUR

- Dans les soins partagés, des médecins de famille travaillent en collaboration avec divers fournisseurs de soins paramédicaux, y compris les sages-femmes. La collaboration avec les sages-femmes peut être accrue lorsque ces dernières participent aux séances d'enseignement interprofessionnel, aux réunions et aux équipes de soins, et lorsqu'on adopte de meilleures normes de communication entre les médecins et les sages-femmes.
- La communication entre les médecins de famille et les sages-femmes qui se partagent les soins aux patientes peut être facilitée par l'entremise de lettres dans lesquelles sont clairement définis les plans de soins, les enjeux liés à la grossesse, et les rôles attendus des sages-femmes et des médecins de famille.
- Il faut offrir aux femmes enceintes qui présentent un herpès génital récidivant un traitement prophylactique par l'acyclovir ou le valacyclovir à la 36^e semaine de gestation et durant l'accouchement, conformément aux lignes directrices actuelles de la Société des obstétriciens et gynécologues du Canada.

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For prophylaxis of a pregnant woman with recurrent genital herpes, the current Society of Obstetricians and Gynaecologists of Canada guidelines recommend offering acyclovir or valacyclovir suppression from 36 weeks' gestation onward.¹ We prescribed 400 mg of acyclovir to be taken orally 3 times daily. We advised the patient that she could continue using this medication after birth for a duration of 2 to 6 weeks, as her last outbreak occurred in the postpartum period. At the time of our assessment she was asymptomatic. For this reason we deferred vaginal examination and the timing of it to the judgment of her midwife.

We sent a letter to the midwife reviewing our consultation on the patient's care. In the letter we outlined the treatment plan for herpes simplex virus prophylaxis. We explained that the patient had not been examined for genital lesions and that we expected this would be performed by the midwife as the patient approached term. We stated that if lesions were found at the time of labour, then a cesarean section should be offered. We made note of the resolved low-lying placenta and the vaginal swab results that were positive for group B streptococcus. Finally, we suggested that the midwife could refer the patient back to us if further concerns arose. Any request for consultation during the intrapartum period should be obtained from the on-call obstetrician. This letter was also reviewed with the patient.

The patient subsequently had an uneventful vaginal delivery of a baby boy at term. She and the baby were discharged from hospital the day following birth. The baby was readmitted the day after discharge owing to a cyanotic episode while feeding. He continued to have transient oxygen desaturations with feedings in the emergency department, and empiric treatment was initiated with ampicillin, gentamicin, and acyclovir until all culture results were negative 48 hours later. All other investigations revealed negative findings and the baby was discharged home 4 days later. He remains healthy and well after his first 3 well-baby checkups and corresponding immunizations.

Literature search

The literature was reviewed to learn more about current standards of midwife-physician collaboration and communication in Canada. PubMed was searched using the terms *Canada*, *midwife*, and *family practice*.

Discussion

There are currently more than 1000 midwives in Canada registered to provide low-risk obstetric care. They function alongside Canada's 2140 family physicians providing intrapartum maternity care and 1650 obstetricians and gynecologists in active practice. As fewer Canadian family physicians are providing intrapartum maternity care each year, midwives might come to play a larger role in the future.²

It is important for family doctors to understand the scope of practice for midwives in their respective provinces. Canadian midwives have a limited formulary of drugs they are allowed to prescribe from. The College of Midwives of Ontario does not include any antiviral medications in its drug formulary.³ Such limitations necessitate effective collaboration with physicians.


The level of midwifery integration within primary care varies substantially in different jurisdictions across the country. For example, midwifery remains unregulated and unfunded by the government in Newfoundland and Labrador, Prince Edward Island, and the Yukon, creating considerable barriers to its integration in these regions.⁴

In regions where midwifery is more readily available, research has indicated some difficulty integrating midwives into the mainstream obstetric community and potential for strained relationships with physicians. In a recent survey in Calgary, Alta, physicians perceived midwives as poorly trained, less able to appreciate the gravity of a clinical situation, and somewhat adversarial. Midwives perceived physicians as authoritarian and lacking understanding of midwives' training, skills, and scope of practice.⁵ Despite such challenges, midwifery has been successfully integrated in some community-based collaborative care models where family physicians, midwives, community health nurses, and doulas might provide care during pregnancy, birth, and the newborn period, with obstetric consultation as required. Examples include the South Community Birth Program in Vancouver, BC, and La Maison Bleue in Montreal, QC.²

Further lessons for the integration of midwifery could perhaps be gleaned from community health centres, of which more than 800 now exist across all provinces in Canada. In community health centres, family doctors share responsibility and collaborate with various allied health workers in the care of patients.⁶ Suggested approaches for improving cooperation and trust between physicians and midwives in Canada include involving midwives in interprofessional obstetric meetings and education; including midwives in collaborative care teams; and implementing standards for collaborative communication between midwives and physicians.⁵

Conclusion

As collaborators, family physicians often work with patients, families, health care teams, other health professionals, and communities to achieve optimal patient care.⁷ In this case we aspired to provide the best collaborative care possible. In particular, communication was facilitated through a letter sent to the midwife outlining our management of the issues referred to us for assessment; reviewing other active pregnancy issues; delineating the role expectations for the midwife in ongoing care; and inviting referral from the midwife in the case of any subsequent concerns. An alternative approach for

communication might have been to attempt to contact the midwife directly by telephone; however, a formal letter was deemed more appropriate in this case. 

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Competing interests

None declared

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