Multidisciplinary care in high-risk pregnancy

What makes a pregnancy high risk

A pregnancy may be considered high risk when maternal health, fetal health, placental function, or the birth process has an increased chance of complications. This can include pre-existing medical conditions such as congenital or acquired heart disease, diabetes, kidney disease, autoimmune disease, epilepsy, severe asthma, thrombophilia, prior venous thromboembolism, significant mental health conditions, or complex medication needs. It can also include pregnancy-related concerns such as hypertensive disorders, fetal growth restriction, placenta previa or accreta spectrum, multiple pregnancy, recurrent pregnancy loss, or a history of preterm birth.

High risk is not a label of failure. It is a signal that the pregnancy may require a broader safety net. A person with stable disease control before conception may still need extra monitoring because normal pregnancy physiology can alter cardiac output, coagulation, renal filtration, glucose metabolism, drug pharmacokinetics, and respiratory reserve. Conversely, some risks emerge only after conception, making flexible planning essential.

Multidisciplinary care is particularly valuable when decisions have trade-offs. For example, anticoagulation may reduce thrombosis risk but affects neuraxial

anesthesia timing and bleeding planning. Cardiac disease may influence recommended birth location, fluid management, and postpartum monitoring. Medication changes may require balancing fetal exposure, maternal disease relapse, and breastfeeding goals. A coordinated team helps these decisions become explicit, individualized, and revisited as the pregnancy evolves.

Who belongs on the multidisciplinary team

The composition of the team should match the person’s risks rather than follow a rigid template. Core members often include an obstetrician or midwife, a maternal-fetal medicine consultation for complex risk assessment, specialist nursing or midwifery staff, and the clinician managing the underlying condition. Depending on the situation, this may include cardiology, hematology or thrombosis medicine, endocrinology, nephrology, neurology, rheumatology, psychiatry, pulmonology, infectious diseases, genetics, nutrition, social work, and pharmacy.

Obstetric anesthesia is a key team member in many high-risk pregnancies, not only at the time of birth. Early anesthesia review can clarify whether epidural or spinal anesthesia is appropriate, how anticoagulants should be timed, whether airway or cardiac concerns require additional planning, and what alternatives exist if urgent cesarean birth is needed. Neonatology may join when preterm birth, fetal anomaly, growth restriction, maternal medication exposure, or neonatal intensive care needs are possible.

Some conditions benefit from a named specialist pathway. Pregnancy heart teams, for instance, typically integrate cardiology, maternal-fetal medicine, obstetrics, anesthesia, pharmacy, and nursing to assess maternal cardiac risk, adapt surveillance, and plan delivery and postpartum care. For people with prior or current venous thromboembolism risk, hematology or thrombosis specialists, maternal-fetal medicine, anesthesia, and sometimes pulmonary medicine, critical care, or interventional radiology may be needed. The most effective teams also include the pregnant person and chosen support people as active participants, because values, symptoms, access barriers, and birth preferences shape safe care.

Preconception and early pregnancy planning

When possible, planning before pregnancy offers the greatest opportunity to reduce preventable risk. Chronic disease optimization before conception may include reviewing disease stability, organ function, prior complications, medication safety, contraception timing, genetic considerations, vaccination status, and whether pregnancy should occur in a local unit or specialist center. This is not about creating a perfect starting point; it is about identifying modifiable risks before physiologic pregnancy changes intensify them.

Early pregnancy is also an important window. A structured intake visit can document baseline blood pressure, renal function, cardiac status, coagulation history, glycemic control, medication exposure, obstetric history, and psychosocial needs. The team may agree on who leads routine pregnancy care, which specialist monitors the medical condition, how often visits occur, and what symptoms should trigger urgent assessment.

A practical early plan often includes:

A concise risk summary that all clinicians can access.
A medication reconciliation, including prescription medicines, over-the-counter products, supplements, and allergies.
A surveillance schedule for maternal labs, imaging, fetal ultrasound, and condition-specific monitoring.
A plan for flare management or decompensation, including who to contact after hours.
A discussion of delivery location, likely mode of birth considerations, anesthesia planning, and neonatal support.

People should not stop or start important medicines solely because of pregnancy without professional advice. For many conditions, untreated maternal illness can pose substantial risk, and medication decisions are best made through pregnancy medication risk-benefit assessment with the relevant clinicians.

Antenatal coordination and shared decision-making

During the antenatal period, multidisciplinary care should feel like a coordinated pathway rather than a series of disconnected appointments. The team may meet formally in case conferences or communicate through shared records,

written care plans, and designated coordinators. For the patient, the practical questions are often simple but vital: Who is in charge of each issue? Who should I call if symptoms change? Which hospital should I attend in an emergency? What is the next decision point?

Good care plans are living documents. They should be updated when new information appears, such as fetal growth concerns, rising blood pressure, medication side effects, thrombosis symptoms, deteriorating cardiac function, or a change in social circumstances. Shared decision-making means clinicians explain the likely benefits, uncertainties, and risks of reasonable options while respecting the pregnant person’s goals and tolerance for risk. It does not mean the patient must carry the burden alone; it means decisions are transparent and collaborative.

Communication is especially important when specialists use different risk frameworks. A cardiologist may focus on maternal hemodynamics, an obstetrician on timing and route of birth, an anesthetist on neuraxial safety, and a neonatologist on gestational age and newborn support. Multidisciplinary review brings these perspectives into one plan. It can also prevent conflicting advice, repeated testing, and delayed escalation.

Emotional wellbeing deserves the same seriousness as physical surveillance. High-risk pregnancy can involve uncertainty, traumatic memories, prolonged hospitalization, financial stress, and fear for the baby. Perinatal mental health support, social work, interpreter services, and culturally safe communication can make the care plan more realistic and more compassionate.

Delivery planning and intrapartum safety

Delivery planning for chronic disease and other high-risk conditions usually begins well before labor. The plan should address the preferred place of birth, indications for induction or planned cesarean, acceptable gestational age ranges, fetal monitoring, blood product availability, intravenous access, medication timing, anesthesia options, and criteria for higher-level care. For some people, vaginal birth remains appropriate and may be preferred; for others, cesarean birth or delivery in a tertiary center may be safer because of maternal or fetal factors.

An intrapartum plan should include what to do if labor starts before the planned date. This matters for people taking anticoagulation, those with cardiac disease, placenta-related bleeding risk, prior uterine surgery, severe hypertension, or fetal concerns. If neuraxial anesthesia is desired, anticoagulant timing may determine whether it is safe. If general anesthesia carries increased risk, early epidural placement may be discussed in advance. These are individualized decisions and require the treating team's guidance.

For cardiovascular disease, the team may plan fluid balance, telemetry, assisted second stage, avoidance of specific medications, or intensive postpartum observation. For thromboembolism risk, the team may plan when to pause and restart anticoagulation, how to manage bleeding, and how to coordinate anesthesia. For diabetes, glycemic protocols may be needed during labor and after birth. For fetal concerns, neonatology may be present at delivery.

The best plans are specific enough to guide urgent care but flexible enough to adapt. Birth is dynamic, and the team should explain in advance which changes would prompt escalation, transfer, operative birth, critical care involvement, or neonatal intensive care.

Postpartum care: the fourth trimester is part of the plan

High-risk pregnancy care does not end with birth. The postpartum period can be clinically vulnerable because blood volume shifts, coagulation remains increased, sleep deprivation affects disease control, and medication needs may change rapidly. Some complications, including venous thromboembolism, cardiomyopathy decompensation, severe hypertension, infection, hemorrhage, and psychiatric crisis, may occur after discharge.

A postpartum plan should state when follow-up occurs, which symptoms require urgent evaluation, how medicines should be adjusted, whether breastfeeding affects medication selection, and who resumes long-term care. For someone with hypertension, this may include early blood pressure review. For someone with diabetes, it may include postpartum glucose testing and insulin or medication adjustment. For thrombosis risk, it may include anticoagulation duration and bleeding precautions. For cardiac disease, it may include monitoring for dyspnea, edema, palpitations, or chest pain, with a low threshold for urgent

assessment.

Postpartum planning for chronic illness should also include contraception, recovery support, mental health screening, infant feeding goals, and communication with primary care. Many people are discharged while still physically recovering and emotionally processing a complex birth. Clear written instructions and a named contact can reduce the sense of being abandoned after intensive antenatal care.

For families, it is reasonable to ask before birth: What follow-up is booked? What warning signs matter for my condition? Which medications continue? Are they compatible with breastfeeding if I choose to breastfeed? Who coordinates my care after six weeks? These questions help transform postpartum care from an afterthought into a planned transition.

How patients and families can strengthen team-based care

Even in an excellent system, patients often become the only constant across multiple clinics. Keeping a concise personal health summary can help: diagnoses, surgeries, medication list with doses, allergies, specialist names, major test results, pregnancy complications, and the current care plan. Bringing this to appointments can reduce repetition and improve accuracy, especially in urgent settings.

It is appropriate to ask for clarification when advice seems inconsistent. Helpful questions include: What is the main risk we are trying to reduce? What are the alternatives? What signs mean I should seek urgent care? How does this recommendation affect birth or breastfeeding? Who has final responsibility for updating the plan? These questions are not confrontational; they are part of safe collaborative pregnancy care.

Support people can also play a meaningful role. A partner, family member, doula, or friend may help track appointments, notice symptom changes, advocate during triage, and support decision-making. For people facing language barriers, disability, transportation challenges, insurance complexity, or previous trauma, asking for interpreter services, social work, patient advocacy, or trauma-informed care is medically relevant, not optional comfort.

High-risk pregnancy can feel like living between ordinary pregnancy hopes and medical contingency plans. A multidisciplinary approach aims to hold both realities: protecting safety while honoring the person’s preferences, dignity, and family life. The goal is not simply more appointments; it is coordinated, anticipatory, compassionate care that helps everyone know what to do next.