Editorials

GENERAL-PRACTITIONER OBSTETRICS AND MATERNITY BED NEEDS

MATERNITY services in most parts of the country are a mixture in varying proportions of two basic types. On the one hand there is the specialist type, based on the obstetric unit of a district hospital in which all deliveries take place, staffed by a team of doctors and midwives under the direction of a consultant obstetrician. In this type, the patient is in the nominal care of the consultant. She is attended at various times by various members of his team, sometimes by the consultant himself.

On the other hand there is the general-practitioner (or private-consultant) type of service. In this the patient chooses her obstetrician who looks after her personally with the help of an attached or chosen midwife. Delivery, for which he takes responsibility, is arranged at a suitable place in the locality. Consultant help and deputies for doctor or midwife are arranged only if and when necessary.

An intelligent patient with a knowledge of maternity services and the prospect of having to make use of them herself, given a free hand to design a maternity service, would undoubtedly reject the team and arrange one in which the patient could choose her doctor and midwife. To do so she would either have to introduce a personal element into the district-hospital-based type, a formidable task, or retain or provide maternity units serving populations much smaller than the 150,000 to 250,000 contained in the catchment areas of district hospitals. Just as women have taken to oral contraception because they want it, despite awe-inspiring warnings of danger, so would she, in spite of similar warnings, arrange local delivery and a personal service.

A subcommittee of the Central Health Services Council reporting on Domiciliary Midwifery and Maternity Bed Needs[1] takes the opposite view. Although of necessity it makes interim recommendations for temporary continuation of domiciliary and local hospital delivery, it has its long-term sights firmly set on a specialist type service based on district hospitals in which all deliveries take place. It recommends eventual closure of all local general-practitioner maternity hospitals and their replacement by combined general-practitioner–specialist units at district hospitals. In these, general practitioners would share the beds and share the work below consultant level by virtue of appointments as clinical assistants or by other unspecified means. They would work in co-operation with the consultants.

The committee does not suggest that general practitioners would be able to provide a full personal service, and take responsibility, for the patients in their own practices. Indeed, it does not consider that continuity of care should be construed narrowly as a continuous personal relationship between a patient and one doctor or midwife. It believes that in present circumstances general practitioners are less than ever providing the personal service recommended by the Cranbrook Committee. It does not discuss the reasons why this should be so. One of the most important is the trend towards hospital delivery coupled with lack of local beds, a factor which will be accentuated by the committee's recommendations. The committee must be well aware of the effect on

general-practitioner participation of arranging deliveries at only one point in a large catchment area. It is obviously aware of one effect on the patient; it recommends hostel beds at district hospitals to which patients from the periphery can be admitted to await the onset of labour in order to ensure that they arrive at the delivery suite in time!

In such a service, however many general-practitioner obstetricians there may be, only those living close to a district hospital could hope to look after their own patients in labour. They would be able to do so only in co-operation with the consultant and if the organization of the hospital permitted. The rest would be able to take responsibility only for antenatal and postnatal care in their own districts. Their hospital work, if any, would necessarily be on a sessional basis, designed to preserve the doctor's familiarity with delivery and to give assistance to the specialist team, rather than provide personal care for the patient.

The report makes frequent mention of the need for team work and co-operation in obstetrics, but the team is not a general practitioner and a midwife, with a consultant to give assistance if needed. It is a number of midwives, many doctors—housemen and general practitioners, perhaps more than one specialist and all under the direction of the senior consultant. An appropriate member of the team who is on duty at the time attends the patient, and may do so without having a sense of responsibility for her except in the affair of the moment. The committee does not appear to appreciate that this sort of team may not be to the liking of the patient, and may not be a satisfactory substitute for personal long-term responsibility. Discussing the general practitioner and the team, the committee states forthrightly that it does not wish to see perpetuated a distinctly general-practitioner-orientated branch of the maternity service. It calls for revision of the general practitioners' system of remuneration for maternity services, without giving reasons but perhaps in the hope of abolishing that personal contract with each individual maternity patient.

Failure to encourage the development of a truly general-practitioner service may nullify some of the committee's wiser recommendations. Unification of midwifery services under a single hospital authority in each area could be advantageous in many ways. It could, as the committee believes, end the division between hospital and domiciliary midwives, but not in an area with no local hospitals. District-hospital midwives would be too far away to make daily visits to the periphery and would not want to be seconded to it. District midwives, like general practitioners, would be too far from the hospital to attend deliveries. It is only from local hospitals that hospital and district midwifery can easily be integrated. Without them it is inevitable that puerperal nursing in the home will be carried out by midwives or nurses who do not attend deliveries, if it is done at all. The committee does not grapple with this problem; it sits on the fence and makes no recommendation regarding early discharge, perhaps fondly hoping that it has not come to stay.

Like so many other authorities, this committee reiterates the view that no delivery can be safe unless it takes place in a specialist hospital. The truth is that most women can be delivered safely anywhere where adequate preparations are made. Antenatal care has been developed to a level at which almost all cases requiring specialist attention can be detected in good time. The dangers of occasional failure have to be weighed against those of failure to arrive at a distant hospital in time, for which a more acceptable solution than hostel beds needs to be forthcoming.

As childbirth has already been made so safe, even in places such as East Anglia and the Netherlands where the proportion of deliveries taking place in hospitals is not high, it is surprising that specialist hospital delivery for all should be regarded as the foundation of recommendations for the future. Perhaps the reason is not hard to find. Evidence was collected from most of the learned bodies and administrative authorities

concerned, but the consumer was not consulted; no evidence was received or requested from any of the numerous womens' organizations who could have spoken on her behalf. Evidence of general-practitioner opinion was obtained from answers to a questionnaire sent to chairmen of local medical committees and from the report of an obstetric working party of the Royal College of General Practitioners.[2] Both emphasized the importance in a maternity service of the general practitioner's rôle as the patient's personal doctor. The committee did not accept this as appropriate in the circumstances, preferring its own interpretation of continuing care. This was not surprising in a committee heavily weighted in favour of consultant opinion; three senior consultant obstetricians to one general practitioner who did not hold even a diploma in obstetrics. Although most of the obstetric diplomates in general practice are young men, youth was not represented on the committee. Of six medical members only one qualified less than 40 years ago, and he in 1933. If the obstetrician members had been in any danger of having to do the spade work in the type of service recommended, perhaps there would have been a difference in one recommendation; that every expectant mother should be seen by a consultant at least twice during her pregnancy. In terms of the latest figures, for 1968, quoted in the report, this is a matter of dividing 1,622,240 antenatal examinations between 555 consultants—for each consultant 32 routine antenatal examinations at each of two sessions every working week!

There can be little doubt that a committee of different composition, having more general-practitioner representation together with evidence from and perhaps representation of the consumer, would have produced a different report.

REFERENCES

1. *Domiciliary midwifery and maternity bed needs.* A report by a subcommittee of the standing maternity and midwifery advisory committee of the Central Health Services Council. 1970. London. Her Majesty's Stationery Office.
2. *Obstetrics in general practice.* The report of a working party. 1968. Royal College of General Practitioners. London.

THE SELECTION OF TEACHING PRACTICES FOR VOCATIONAL TRAINING

The College Council published in this *Journal*[1] in August its considered view on the selection of teaching practices for vocational training. This is an important step at a time when the administrative framework for postgraduate training, vocational and continuing, is being redesigned and strengthened. Many regional postgraduate committees are now appointing general-practice subcommittees and some have already appointed regional advisers.

The first of the 12 clauses of this document is perhaps the most likely to cause controversy. "Teaching practices should be selected by the general-practice subcommittee of the regional postgraduate medical committee, which should include university representatives. As is usual in academic selection, there should be no appeal from its decision". The selection of trainers for the trainee practitioner scheme has been for 20 years the statutory duty of the local medical committees' training subcommittees. Even if the responsibility is transferred to the regional committee, *some* local organization is essential, so that local knowledge can be sought and used. Whether the local responsibility should remain with the local medical committees is a matter for debate. That method will be best which ensures the selection of doctors most interested in teaching,