AFTER DELIVERY CARE

Sir,

My colleagues and I have recently been uncomfortably aware that, whereas the well-baby clinic is used to saturation point in the neonatal and postnatal period, the recommended six-week postnatal examination of new mothers is all too easily overlooked.

There are, of course, reasons for this: one is that caring for her baby takes precedence in the mother's mind over possible medical needs, and another is that one of the objectives of the postnatal examination, the provision of contraception, is increasingly being catered for by the maternity hospitals who often give the Pill to mothers as they leave hospital.

Until recently, we had in our practice a well-baby screening clinic, run by the health visitor and a general practitioner, a contraceptive service, including intrauterine device fitting, run by the same doctor, and an antenatal clinic, which was also attended by new mothers for postnatal examination: three needs, fulfilled by three separate clinics.

Aware of the shortfall in our postnatal attendances, and occasional unwanted pregnancies occurring through failure to use the contraceptive service, we started the following system early in 1978.

The well-baby screening clinic continued unaltered. We had already divided it loosely into immunizations, routine assessments, and casual consultations, in that order, and most of our mothers came at the right time, despite the absence of a rigid appointment system, thanks to the efforts of the health visitor.

Now we began a separate session for the babies' mothers, also without appointments, at the same time as the routine assessment session. At once, it became possible to provide, simultaneously, six-week assessment for the new baby and routine postnatal examination for the mother, including contraceptive advice. The two practitioners involved agreed to spend alternate months in the two surgery sessions, the baby clinic being supported by the health visitor, and the postnatal services by the district nurse.

The patients have been full of praise for the system, which has eliminated several time-consuming journeys: what would have meant two or three visits under the old system now means only one.

In the first full year since we started the scheme, we have had 97 deliveries. All 97 babies were screened at six weeks, and 93 out of the 97 mothers accepted the offer of postnatal advice. One third had intra-uterine devices fitted, most of the others having appropriate oral contraception. Postnatal problems were identified and managed on conventional lines.

Discussion with other partnerships and review of the literature suggests that this new service has not previously been recorded, and I should be most interested to have readers views on this.

R. S. DENISON

6 Bruntsfield Terrace
Edinburgh EH10 EY.

TRAINING IN OCCUPATIONAL MEDICINE FOR GENERAL PRACTITIONERS

Sir,

Occupational medicine has now gained a position of importance, as illustrated by the recent establishment of the Faculty of Occupational Medicine in the Royal College of Physicians, London.

As the teaching of occupational medicine is often of mixed quality in some undergraduate training, we decided to try to introduce some postgraduate teaching of this subject for general practitioners. The Specialty Training Group in Occupational Medicine in the North Western Region passed on the suggestion to the Regional Adviser in General Practice and the Specialty Training Committee in General Practice and it received a sympathetic and helpful response. The importance of awareness of occupational medicine as a part of a general practitioner's training was recognized and as a result, course organizers invited one of us (RLM) to talk to various groups of trainees on their day release course. The aim was to introduce occupational medicine from the point of view of general practitioners working in their consulting rooms and in factories.

Our general impression was that the trainees had not previously been aware of the scope of occupational health practice, nor of its growing importance, and that should opportunities to study the subject become more easily available, they would be keen to take advantage of them.

Encouraged by this interest, we wondered whether established practitioners might also react favourably if such opportunities were made available to them. One of us (RLM) attends several factories as a part-time medical adviser and so he invited local general practitioners to spend up to half a day at a factory in order to see something of the scope and practice of occupational medicine. The response was gratifying: 90 per cent of those invited attended.

Following these visits the relationship between the factory medical departments and the general practitioners whose patients work at the factories greatly improved and has been maintained and strengthened.

Our experience with both groups, trainees and established general practitioners, has further encouraged the Specialty Training Group in Occupational Medicine to recognize that postgraduate education in occupational medicine should not be restricted to those who intend to practise occupational medicine, whether part time or full time.

It is hoped that regional specialty advisers and others responsible for training will be encouraged to develop courses in occupational medicine along similar lines, particularly for trainee general practitioners.

R. L. MARCUS
W. R. LEE

Unsworth Medical Centre
Parr Lane
Unsworth
Bury BL9 8JR.

HOME VISITING IN A NORTH-EASTERN MINING COMMUNITY

Sir,

Pereira Gray (1978) in his James Mackenzie Lecture referred to home visiting rates and quoted figures from Fry (1972) and Marsh (1968) which were quite different from my own experience.

I report home visiting rates for the years 1969 to 1978 inclusive for one partner in a group of three with equal workload, and a practice list of just over 9,000 patients (Table 1).

The visit rate per patient has been calculated for the visit rate per household assuming an average number of patients per household determined from a pilot study. I refer to the number of visits, not the number of patients seen, and night visits exclude maternity, road traffic accidents, and problems with dental haemorrhage.

A high visiting rate is not offset by a low surgery consultation rate as the figures for three separate years for one partner show (Table 2).

These figures suggest that home visiting rates in this North-East mining village remain high in comparison with previously published rates, and confirms that mining villages are areas of high demand.

IAIN A. MACRAE

North Farm
Murton Village
Seaham SR7 9RP.

References

Fry, J. (1972). Twenty-one years of general