THE PAST AND FUTURE OF MATERNITY SERVICES*

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ARTHUR GALE, to whose memory this lecture is dedicated, was especially interested in epidemiology and education, but I am sure he would approve an obstetric subject for this year's lecture knowing the exceptional interest taken in obstetrics by members of our College, and especially by members of the South-west Faculty for whom he did so much in the early years.

Our members' interest in obstetrics reflects that of most general practitioners and was shown in answers to a questionnaire sent out by the Postgraduate Education Committee of College Council (1957). The committee reported

> One of the most striking points brought out by answers to all sections of the questionary was the pride of place still held by obstetrics in the hearts of general practitioners. It comes easily first in all lists of subjects, whether for house appointments, or for more courses or for special interests. This is of great interest when one considers how the field of opportunity in obstetrics has shrunk for general practitioners in recent years.

It is strange that opportunity should shrink while enthusiasm remained but before the National Health Service started it had shrunk, almost to vanishing point in some parts of the country. We must look into the past for the reasons, for we must be aware of the forces responsible if we are to understand the present and guide development in the future.

The obstetric past

Independence of midwives

Midwifery became controlled in 1902 when the Central Midwives Board was formed. Physicians, surgeons, public health authorities and the government were all represented, and so were the midwives themselves who held one of the nine seats on the original Board.

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By 1921 they held five seats out of 13 and have held approximately that proportion since then. From 1918 onwards decisions by the Board have required approval by the Minister of Health and to that extent represent the policy of the government.

For many years the Board regarded the midwife as an independent practitioner of normal midwifery, and as recently as 1964 emphasized in its annual report that " Midwives are by statute entitled to accept responsibility for normal childbirth without supervision " and in the same report "A midwife is a practitioner of normal midwifery in her own right ". This cult of midwife independence except when an abnormality became apparent to her, was one which was bound to have an important effect on the obstetric work of the general practitioner by limiting his contact with normal patients.

Since 1937 the Central Midwives Board has not attempted to state exactly what abnormality is, in the rule book which it issues for the guidance of midwives. Before 1937 normality was given a wide range and the tradition lingered on for many years. For instance, breech delivery was categorically stated to be normal, and hypertension did not appear on a list of abnormalities for which a doctor must be called. A midwife could legitimately look after a patient with toxaemia until the appearance of albuminuria, a sign of impending foetal death, or a breech delivery until the head was held up by an incompletely dilated cervix and a doctor might be given the chance to see the patient only at that late stage.

From 1934 onwards independence became a little less complete because the Central Midwives Board advised midwives to offer their normal patients two antenatal examinations by a doctor. The local authorities who had to supervise the midwives in their areas arranged for these examinations to be carried out at their clinics of which, as a report by the Royal College of Obstetricians and Gynaecologists and the Population Investigation Committee (1948) has shown, there were nearly 2,000 by 1944, but even then one patient in six did not attend a clinic and was looked after entirely by a midwife.

The Central Midwives Board did not, and perhaps could not, give an independent midwife discretionary powers to make use of new drugs and new techniques as they became available. As she did not have the support, at normal labours, of a doctor who could take responsibility for her use of new ideas, she could not move with the times until the Board itself had approved a new method, and until she had been instructed in the use of it. Trilene is an example. It became established as a good and easily portable analgesic in 1946 and was being used by patients who had booked doctors to attend their deliveries but, as the annual report of the

Board (1956) shows, the independent midwife could not use it until nine years later and only then after attending a course of instruction.

Pupil midwife training

The arrangements for training pupil midwives were another factor which had a considerable effect on general-practitioner obstetrics. Pupil midwives are used as a labour force. This is quite evident because a midwife is expected to take more patients, not less, if she has a pupil to train; the opposite of a general practitioner with a trainee assistant. Many pupils take only Part 1 training, 130 for every 100 eventually enrolled as represented by the first two columns of figure 1. The remaining columns show the proportion

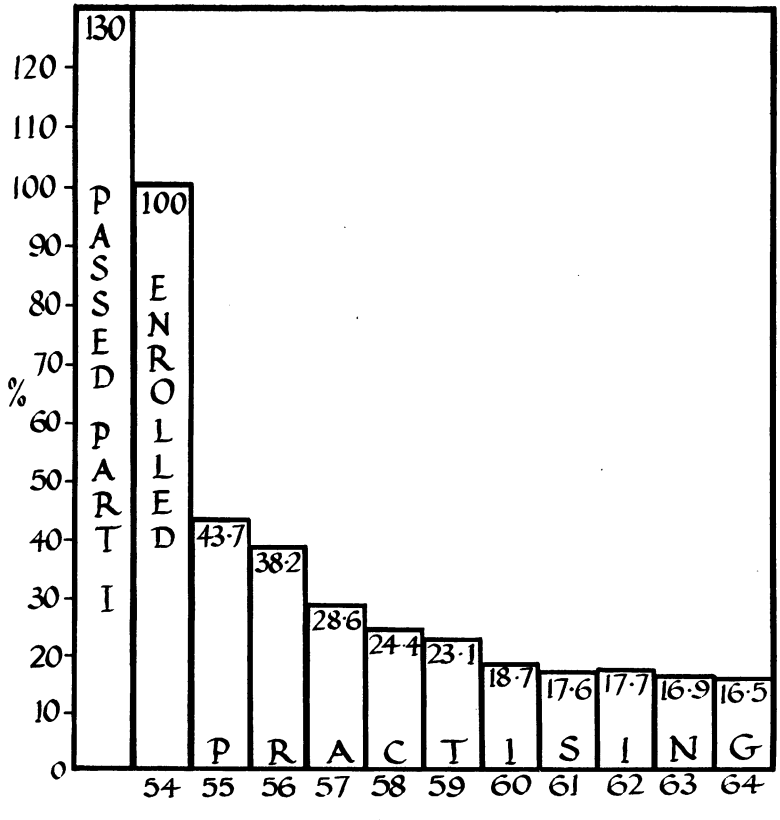

Figure 1.
A comparison of the numbers of pupil midwives who pass Part 1, who are enrolled, and who practise midwifery in each of the ten years after enrolment

of those enrolled in 1954 who practised as midwives in each of the next ten years, starting with only 43 per cent in 1955 and falling to 16 per cent ten years later. The majority did not practise after enrolment and their value to the maternity services was only that of the work they did while training.

A pupil midwife had to attend a specified number of deliveries, deliver both baby and placenta herself and attend mother and baby for ten days after delivery. If a doctor delivered even the placenta, the pupil lost the case for her collection and an unintended result was that midwives who were training pupils were reluctant to have a doctor at delivery and reluctant to send for medical aid early, hoping that with a little patience, the case would not be spoiled for the pupil. In part it was absorption during training of the idea of doing without a doctor that made midwives take pride in their ability to manage without medical aid. In this they were encouraged by the Central Midwives Board's reservation of the status of midwife for those who practised independently. A midwife who looked after a patient who had booked a doctor to attend her delivery was called a maternity nurse, a lower status which she disliked and avoided if she could.

A great debt is owed to the National Birthday Trust Fund's Perinatal Mortality Survey carried out in 1958 for providing information about the maternity services at that time. A report by Butler and Bonham (1963) showed who delivered the babies and who was the senior person in the delivery room at the time. In specialist hospitals the proportion of babies delivered by various members of the staff was

	per cent
Specialists (consultants and senior registrars)	*11.2*
Hospital medical officers (below senior registrar rank)	*6.7*
Midwives	*33.6*
Pupil midwives or medical students	*47.6*

The senior person present at deliveries by pupil midwives, either in hospitals or homes was

	per cent
Specialists	*1.5*
Hospital medical officers	*9.3*
General practitioners	*5.3*
Midwives	*83.9*

Evidently pupil midwives deliver a large number of the patients in specialist hospitals, supervised not by specialists but by midwives who are largely responsible for the practical side of pupil training

and could carry it out equally well in general-practitioner hospitals.

But the Central Midwives Board rarely, if ever, approves for pupil training hospitals in which there is no specialist control. Consequently in order to train a large number of pupils of whom the majority will never practise as midwives, 150,000 normal patients each year, the number required for pupil training, have to go into specialist hospitals. They are taken partly or completely out of the care of their general practitioners who are well able to look after most of them, and general-practitioner hospitals have to be staffed without the help of pupil labour.

Obstetricians

Most medical schools taught obstetrics from about 1830 onwards but only the Society of Apothecaries, who were the general practitioners of that time, already examined in it when the General Medical Council was set up in 1854. For 32 years the General Medical Council itself was content with a qualifying examination in medicine and surgery only, and did not add obstetrics until 1886. Specialist obstetricians were physicians, but there were very few and the practice of obstetrics was mainly in the hands of general practitioners, many with long experience and considerable skill acquired by apprenticeship methods but no higher qualifications.

There was no higher qualification in obstetrics until 1928 when the Society of Apothecaries, still to the fore, introduced its diploma of Master of Midwifery which combined obstetrics with paediatrics, a very suitable combination for a general practitioner. However, in the following year, 1929, a group of surgeons founded the College of Obstetricians and Gynaecologists, later to become Royal, and it became that college's policy to combine obstetrics with gynaecology, a policy pursued so successfully that there was soon no place for an obstetrician who was not also a gynaecologist, to the disadvantage of any general practitioner who wished to make a specialty of obstetrics.

Incorporation of the new college was resisted by the Colleges of Physicians and Surgeons, but their opposition died down when a clause was written into its charter which permitted it to hold or take part in a qualifying examination only if invited to do so by some body already holding such an examination. This removed the implied threat to the Conjoint Board's examination which the physicians and surgeons did not invite the obstetricians to share. They introduced their own diploma, the D.Obst.R.C.O.G., in 1931, not as a qualifying examination which was forbidden but as an indication of fitness for general-practitioner obstetrics. Candidates were required to have held for six months a post as house surgeon in a specialist maternity hospital, not an unreasonable condition at a

time when normal maternity was in the hands of midwives who would call a doctor only to abnormal cases. Fletcher Shaw (1954), who first suggested the diploma, and later became President of his College, hoped that it would be taken by the Minister of Health as a criterion for acceptance on a local list of doctors who would give help to midwives in difficulties. In fact he foresaw an ' obstetric list ' 18 years before it came into existence, and he may or may not have foreseen that such a list would stimulate a demand for the diploma and ensure a supply of house surgeons for maternity hospitals.

At first, new members of the College were selected from diplomates which gave the diploma a good start until the College introduced a membership examination in 1936, but very few diplomas were awarded during the war years and only 110 in 1946, the first year thereafter. It began to climb to its present position as the most popular postgraduate diploma only under the stimulus of the National Health Service and the obstetric list.

When the National Health Service Act was in the drafting stage, the College published a report entitled "A Report on a National Maternity Service" (1944) in which it recommended that one specialist maternity hospital in each part of the country should be a teaching hospital with a whole-time professor living in or near the hospital. Medical student training is often given as a reason why specialists must have normal deliveries in their hospitals. As for pupil midwives, the Perinatal Mortality Survey showed who was the senior person present at deliveries by medical students in 1958, a specialist in 2.0 per cent, a hospital medical officer in 20 per cent, a general practitioner in 0.15 per cent and a midwife in 77 per cent. The practical side of student training was in the hands of midwives and most of the small proportion given by a doctor came not from specialists but from hospital medical officers, some of them no doubt destined eventually to become general-practitioner obstetricians. If training could be left to midwives and hospital medical officers, then clearly general practitioners could play a much larger part and there is no need for a large number of normal deliveries in specialist hospitals for that purpose.

The 1944 report was quoted by the president of the College when he addressed the 12th British Congress of Obstetrics (Gilliat 1949). He pointed out that in 1947, 86 per cent of patients were delivered by midwives, and went on to confirm the view of his College that one of the essential principles without which a maternity service could not be built was that normal maternity should remain as it had been, in the hands of midwives. He also said that it would be neither wise nor economical to encourage competition between

general practitioners and midwives for the care of normal labour.

There is no evidence here that his College foresaw that the time would come for co-operation between doctors and midwives in normal cases. It is very clear that he was in favour of a midwives' service in which doctors with special experience, such as those holding the diploma, would be called in by independent midwives to deal with emergencies.

General practitioners

Since its formation the interests of the midwife have been in the hands of the Central Midwives Board, more than one-third of its members being midwives. Since 1929 the interests of the specialist obstetricians have been in the increasingly powerful hands of the fellows of the Royal College of Obstetricians and Gynaecologists. The third member of the obstetric trio, the general practitioner, had no such backing. He had no association of his own and his possession of the D.Obst.R.C.O.G., if he held it, gave him no voice in that College which could not be expected to protect his interests unless they were similar to those of its members; in fact some were diametrically opposed. How did he fare in the recent past before the coming of the National Health Service?

For his experience of normal maternity he had to depend almost entirely on his patients' willingness to pay, and very few would pay for what are now called complete maternity services even at nominal charges. Their inclination to pay a doctor grew less as handywomen were replaced by trained self-sufficient midwives, but some would pay for attendance at delivery and about one domiciliary patient in four did so, mainly for the sake of chloroform analgesia which had no real rival. Minnett's gas-air machine was being developed in 1932 and many a general practitioner of that time owes much of his experience of normal delivery to the fact that delay before new advances became available to midwives was so great that 14 years later in 1946, the year in which trilene made gas and air obsolete, only one midwife in five was qualified to use gas and air and many of those qualified could not do so for want of a machine or transport for it. In the meantime the general practitioner's chloroform had reigned supreme.

Apart from chloroform almost everything was against him. The patient who booked a doctor to attend her delivery reduced her midwife to the status of maternity nurse and was not encouraged to do so. A doctor could not compel the co-operation of an unwilling midwife whose independence in a wide range of normality was warranted by the Central Midwives Board and approved by the Minister of Health to the satisfaction of the Royal Colleges of Obstetricians and Midwives. The general practitioner whose mid-

wives were willing to forgo their independence was fortunate. The rest found it wiser and better not to try to interfere unless help was requested. When called in an emergency there was little hope of help from the hospitals which before 1929, when local authorities were allowed to run maternity hospitals, had beds for only 20 per cent of deliveries. Even in 1937 when there were beds for 40 per cent, most were in London and the big towns, so that the South-west, for instance, could admit only 25 per cent and Wales only 17 per cent, including those normal cases needed for training pupil midwives, figures which show that many abnormal cases had to be dealt with at home. Specialist help was rarely available because the number of specialists was small. The general practitioner had to do what he could for the patient himself or call a colleague with special experience. He did his best with the tools available but maternity work could be a series of hair-raising adventures in dealing with abnormality in difficult circumstances without specialist help, a game which, after a few unlucky experiences, might seem not worth the candle.

Candle is an appropriate word. Early in my time in general practice I was a locum in a small town in Cheshire where the doctor had said that there were no maternity cases pending. When he said that, there was a primigravida whom he had never seen or even heard of, in labour under the care of a midwife and a medical aid call came that night. The patient was in a small country cottage in a bedroom lit by candlelight. She had been in the second stage for quite a long time with an occipito-posterior, and the foetal heart was irregular. The nearest maternity hospital was ten miles away and there really was no alternative to a forceps delivery by candlelight, which if it had not been an easy one might well have qualified as a basis for one of those horrifying tales that are still told about failed forceps deliveries in general practice. This is quite a fair example of the type of case that general practitioners in the nineteen-thirties might have to tackle in response to calls for medical aid, cases that they had no opportunity to foresee, prevent or direct into specialist hands.

From 1936 onwards local authorities had to arrange a comprehensive maternity service and some arranged for midwives, in areas where there was no clinic, to refer patients to their general practitioners for their two antenatal examinations. Thus for the first time general practitioners were paid from public funds to attend antenatally some of those patients to whom they might be called in labour, but the number was very small and amounted to only five per cent of all cases in 1944.

In many of the big urban areas where local authorities provided maternity hospitals they were staffed by whole-time specialists.

Provision of these hospitals was most acceptable to the Central Midwives Board which wanted specialist beds for pupil training, and to the obstetricians who wanted specialist posts. The general practitioner lost not only the patients attracted into hospitals from which he was excluded. Some hospitals took over the domiciliary work in the neighbourhood, as for instance, Guy's Hospital had done. That hospital between 1928 and 1937 dealt with all the maternity work for a population of 87,000 including nearly 1,000 domiciliary deliveries a year, leaving little or none for the general practitioners.

In contrast to urban areas, general-practitioner obstetrics was perhaps at its best in some of the smaller towns where the maternity hospital, too small for whole-time specialists and pupil training, was staffed by local general practitioners who, if they were fortunate enough also to staff the local authority clinic, saw their patients twice antenatally as well as in response to medical aid calls, but even in these circumstances midwife independence tended to restrict their participation in the care of normal patients and their potential value to the maternity services was not fully realized.

To sum up the conditions in general-practice obstetrics before the start of the National Health Service, in the nineteenth century the apothecary, who later in the century became the general practitioner, was the only person with obstetric training available to the expectant mother. In the twentieth century he was gradually displaced by trained midwives, by local authority clinics and by hospitals from which he was excluded until his share was little more than an emergency service in support of midwives, that part of the maternity service which no one else could, or would, provide. This was not his wish, nor his fault. The basic causes were policies which favoured a midwives' service and gave the midwife a degree of independence so great that it deprived the general practitioner of experience of normal maternity, gave him no opportunity to intervene in the early stages of abnormality, and when he was called in, often required him to deal, in the home, with situations worthy of a specialist team in hospital.

The National Health Service

The 1946 Act gave the patient herself direct access to a doctor who was to provide or arrange all the maternity services required. The new order was made to appear to be a continuation of the old by regulations which permitted and to some extent encouraged him to delegate all except two antenatal examinations to the midwife, but the change, giving the patient direct access to a doctor and not only when the midwife arranged it, was in fact revolutionary. It was made against the wishes of the obstetricians and midwives. It may

have saved family-doctor obstetrics from oblivion and it made a renaissance possible.

Every general practitioner was given the opportunity to supervise expectant mothers from the diagnosis of pregnancy onwards, and moreover to arrange specialist attention whenever it was needed. It soon became obvious to the doctor who accepted this opportunity that in many cases he should leave off where formerly he began; that he should hand over to a specialist at or even before the point at which the midwife formerly called him in; that rather than, for instance, run the risk of being called to a second twin presenting transversely with an arm prolapsed and requiring internal version, he should take charge of antenatal care and have multiple pregnancies transferred to specialists.

Regulations may be changed overnight but in practice the change is less rapid. General-practitioner reaction was slow for obvious reasons. Many had practised for years under the old conditions and were not familiar with normal maternity. They could not easily change their ways nor was it apparent, at first, that there was any need to do so. A full service required a big increase in antenatal care together with attendance at the confinement and in the puerperium. Intrusion was resented by midwives for it reduced them to the status of maternity nurses, a distinction not abandoned until 1960.

The Perinatal Mortality Survey showed how general practitioners had reacted by 1958, ten years after the Health Service began. Figure 2 shows the average number of antenatal examinations a patient received according to the source of antenatal care. If it came entirely from a specialist clinic it was 9.7 examinations and if entirely from a general practitioner 9.1. It is evident that the quantitative difference between the average general practitioner and the average specialist clinic was already insignificant.

In 1958 the general practitioner's responsibility for the confinement was to attend if he thought it necessary or if he was called by the midwife. The Perinatal Mortality Survey gave figures only for attendance at delivery and figure 3 shows the proportion attended by a doctor according to place of delivery. The first two columns compare specialist hospital deliveries with those under general-practitioner care in homes or general-practitioner units. A higher proportion was attended by a doctor in specialist hospitals, 31 per cent compared with 21 per cent, but there were far more abnormal deliveries in specialist hospitals; these are shown hatched. The remainder of each column represents normal deliveries and shows that a higher proportion of these was attended in homes or general-practitioner units. A patient having a normal delivery was more

likely to be attended at delivery by a doctor if she was under general-practitioner care.

The evidence of the Perinatal Mortality Survey is that the general practitioner who in 1958 had to carry out only two antenatal examinations to earn his fees, in fact provided nine, almost as many as a specialist clinic, and in addition was present at a higher proportion of normal deliveries than was attended by a doctor in hospitals. In view of his position ten years earlier, this response to the opportunities offered by the National Health Service clearly shows that general practitioners were interested in obstetrics and were quite willing to provide a maternity service.

The third column of figure 3 shows rather surprisingly that nearly half the deliveries taking place elsewhere than in homes or hospitals were attended by a doctor. The meaning of this is not completely clear from the published information but the probability is that most of the attended deliveries were in private nursing homes, and as the diagram shows, most were attended by general practitioners.

Perhaps more important than the response of the present generation to the opportunities offered by the Health Service is that of the next generation. Although in the early years admission to the obstetric list was given to almost all the established general practitioners who asked for it the intention was to restrict admission to those with special experience. The Royal College of Obstetricians and Gynaecologists suggested that the criterion should be six months' experience as a house surgeon in a maternity hospital and a young doctor with this experience was sure of admission especially if at the end of it he took the diploma. Figure 4 shows the number of diplomas awarded annually from 1946 onwards. After a sharp peak in 1948, probably due to doctors returning from the forces, there was a steady rise to 500 in 1958. In 1959 the Minister of Health received the report of the Maternity Services Committee, which recommended that the criteria for admission to the list should be made very similar to those for admission to the diploma examination and should be strictly enforced. He accepted its advice only in part but this gave such a boost to the diploma that awards rose to 650 in 1960 and to 684 in 1964.

This figure is close to the annual entry into general practice. As not all house surgeons take the diploma and as the pass rate is only 60–70 per cent the number having held a house-surgeon post may be much higher; but all do not go into general practice. The position in the country as a whole is difficult to ascertain, but figure 5 shows what is happening in the Gloucestershire Executive Council area where there are 440 principals in general practice of whom only 17 per cent hold the diploma. The figure shows the proportions who

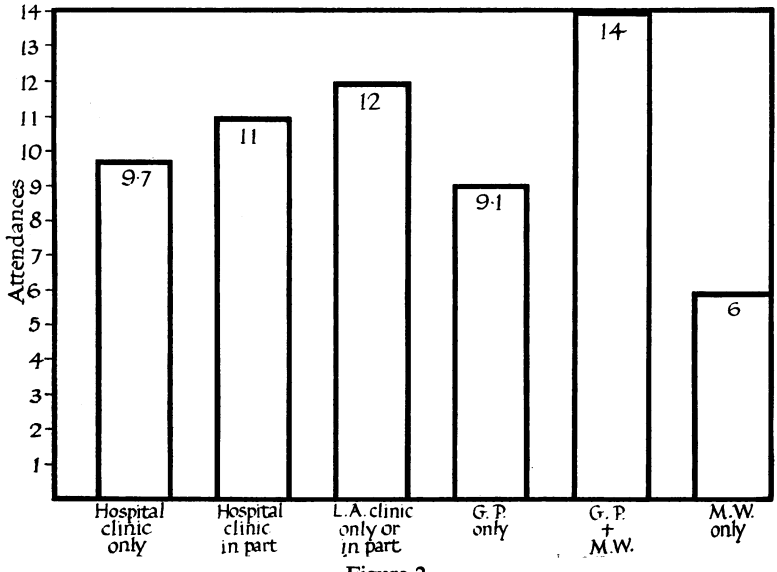

Figure 2.
The average number of antenatal examinations a patient receives, according to the source of antenatal care

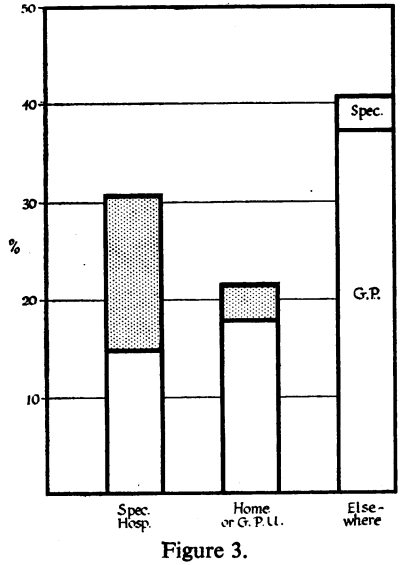

Figure 3.
The proportion of deliveries attended by a doctor, according to the place of delivery. Abnormal deliveries in specialist hospitals, homes or general practitioner units are shown hatched. Deliveries elsewhere are divided into those attended by specialists and general practitioners

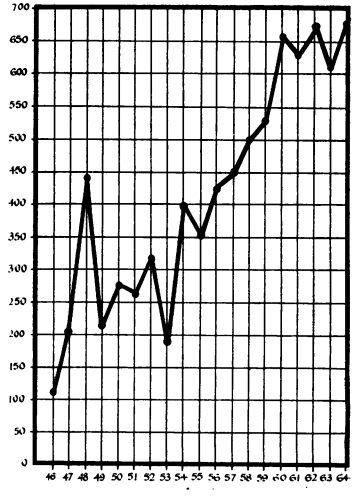

Figure 4.
The number of diplomas in obstetrics awarded each year from 1946 to 1964 by the Royal College of Obstetricians and Gynaecologists

have held house-surgeon posts and the proportions who also took the diploma according to year of qualification. In the group which qualified in 1947–1950 only 20 per cent had been obstetric house-surgeons and half of these held the diploma, but the numbers increase in each age group until in the 1959–1962 group 75 per cent had been house surgeons and 43 per cent held the diploma. That was the position in 1965 when some of that group had been qualified for only three years; the final figure for diplomates may well be higher. There can be no doubt that the existence of the list has caused many doctors to show their interest in obstetrics by taking house surgeons posts and diplomas; so many that it is evident that the rising generation is taking such an interest in obstetrics that eventually a large majority of general practitioners will have had special experience in that subject.

The Royal College of Obstetricians and Gynaecologists in 1954 published a report on "An Obstetric Service in the National Health Service" in which it stated that the number of general-practitioner obstetricians should bear a direct relation to the work to be done and forecast that regulating, meaning limiting, the number might become necessary. There is, however, the alternative of relating the amount of work to the number of general-practitioner obstet-

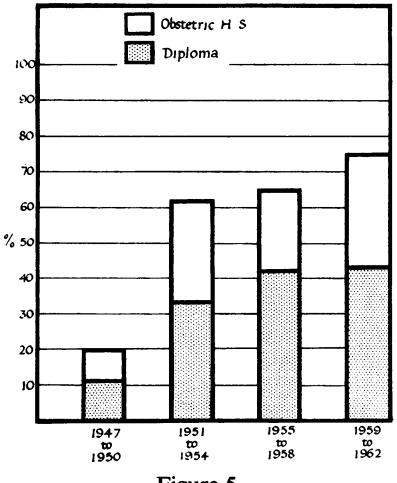

Figure 5.
Principals in general practice in the Gloucester County and City Executive Council area who hold a diploma in obstetrics or have been obstetric house-surgeons, according to the year of qualification

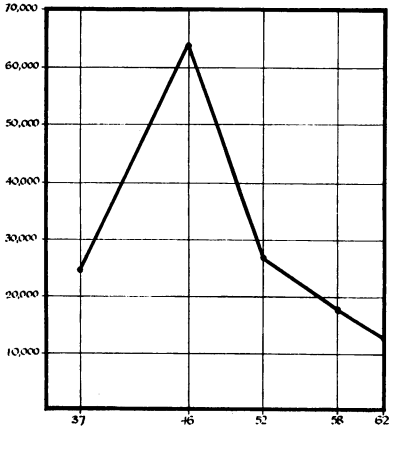

Figure 6.
The number of deliveries in private nursing homes between 1937 and 1962

ricians. The College's efforts are now providing so many ex-obstetric house surgeons for general practice that it must begin to think not of limiting their numbers but of giving them a larger share of the work available, a share the size of which depends on two factors, the number of domiciliary births and the number of general-practitioner beds, one of which must be increased if their share is to increase.

Home delivery is approved by the Central Midwives Board but the policy of the Royal College of Obstetricians and Gynaecologists is that beds should be provided for all who need them, or will accept them. In view of the persuasive propaganda put out in recent years it is surprising that the number of home births has not fallen greatly. It has not done so because the birth rate has risen, due to women having babies at an earlier age, as fast as new beds could be provided, but, unless there is an increase in the size of the average family, the birth rate will soon begin to fall and beds will be available for a higher proportion of births. If they are filled, some of the domiciliary work will be transferred to hospitals and as four-fifths of the hospital beds are in specialist hands, most of it will be taken over by specialists.

The number of beds available to general practitioners, the second factor on which their share of the work depends, was reduced in the early years of the National Health Service. Figure 6 shows the number of deliveries in private nursing homes which rose rapidly from 1937 to 1946 until nursing-home beds accommodated 64,000 deliveries a year; figure 3 suggested that most births in private nursing homes were attended by general practitioners. When the National Health Service provided free beds in maternity hospitals the number of births in private nursing homes began to fall and was down to 12,584 by 1962, a fall equivalent to the loss of 1,600 beds. The number of general-practitioner maternity beds provided by the National Health Service was 2,911 in 1956 and rose slowly to 4,090 in 1964.

In 1959 the report of the Maternity Services Committee recommended that all general-practitioner obstetricians should have access to beds and that all new beds should be general-practitioner beds wherever possible. Figure 7 shows the number of new general-practitioner beds each year since then, starting with

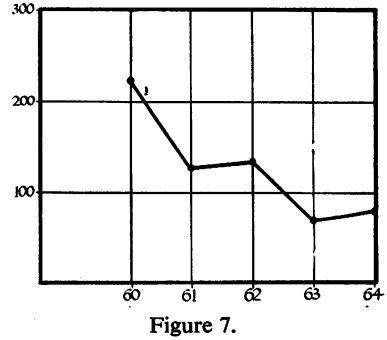

Figure 7.
The number of new general-practitioner maternity beds provided each year from 1960 to 1964

222 in 1960 and falling to 78 in 1964, a year in which specialists took 86 per cent of the new beds. In the five years after the Maternity Services Committee reported, the general practitioners' share of maternity beds increased from 17.7 per cent to 19.3 per cent, a tiny gain of 1.6 per cent. At that rate of growth general practitioners would attain a half share in the country's maternity beds in rather less than 100 years.

The policy for maternity beds of the Royal College of Obste-

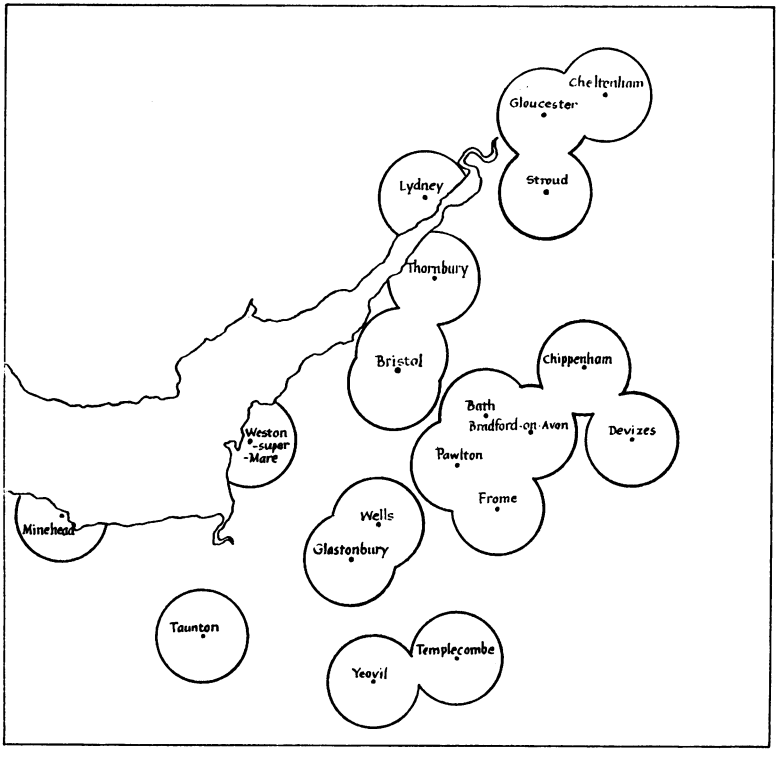

Figure 8a.
The South-west region showing circles drawn at a distance of five miles around each hospital which will have maternity beds in 1975. There will be district hospitals at Gloucester, Cheltenham, Bristol, Bath, Weston-super-Mare, Taunton, Yeovil, Barnstaple, Exeter, Torquay, Plymouth, Devonport and Truro

Figures 1 and 6 were compiled from Annual Reports of the Central Midwives Board, figures 2 and 3 from the National Birthday Trust Fund's Perinatal Mortality Survey, figure 4 from information supplied by the Royal College of Obstetricians and Gynaecologists, figure 5 from the Gloucester County and City Executive Council's records and the Medical Directory 1966, figure 7 from the Annual Reports of the Ministry of Health and figure 8 from the Ministry of Health's Hospital Plan for England and Wales.

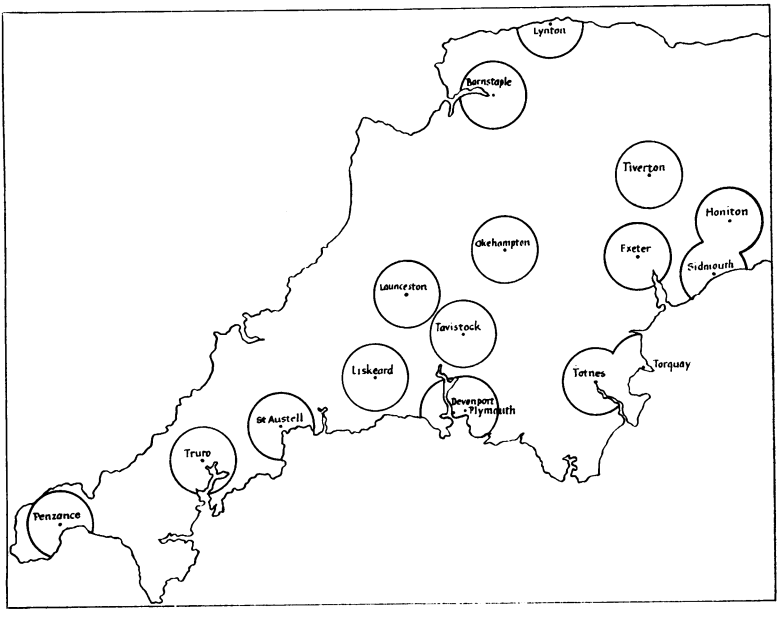

Figure 8b.

tricians and Gynaecologists (1960) recommends large hospitals each serving a population of 250,000, in which all the antenatal beds and four-fifths of the lying-in beds would be under specialist control, leaving 25 beds to be shared by those of the 110 general practitioners living in the catchment area of such a hospital who were near enough to make use of them. The College (1962) does advise that small general-practitioner hospitals at a distance from the main hospital will be essential in some areas, but its policy is more likely to preserve the present 4 to 1 ratio than to give general practitioners a larger share.

The Ministry of Health's Hospital Plan for England and Wales (1962) favours smaller district hospitals catering for populations of only 150,000 but it does not show how beds will be apportioned between specialists and general practitioners. Under this plan by 1975 the South-west will have 17 district hospitals which will contain three-quarters of the region's maternity beds. The remaining quarter will be in 22 peripheral hospitals, fewer than at present, and closure of more, after 1975, is forecast.

A general practitioner can work on a sessional basis as a clinical assistant at a specialist hospital many miles from his home, but if he is to be responsible for his own patients in labour in a general-practitioner hospital where there is no resident doctor, he must live

close to the hospital, say within five miles. Figure 8 has circles drawn at a distance of five miles around each of the hospitals in the south-west region which will have maternity beds in 1975. It is evident that many general practitioners will live within five miles of beds especially in the northern part of the region, and we must hope that there will be general-practitioner beds in every one of these hospitals. If, however, the peripheral hospitals were closed, concentrating maternity work in district hospitals, very few doctors would be within five miles of beds, and the position would be even worse if the larger hospital catering for a population of 250,000 were adopted. It is evident that peripheral hospitals must remain and increase if the Maternity Services Committee's recommendation that all general-practitioner obstetricians should have access to beds is to be implemented.

The future

What sort of a maternity service shall we have in the future if development continues along the present lines under the control of the forces that have influenced it in the past?

Three things can be predicted with some certainty, that there will be fewer babies born at home, that there will be no substantial increase in the number of general-practitioner beds, and that there will be a big increase in the number of family doctors with special training in obstetrics.

A domiciliary service is quite compatible with good results as Holland has been showing us for many years, but its success depends on support from specialists and local authorities. If specialists continue to advocate, and plan for, hospital delivery for all, and if local authorities provide, for instance, bicycles for their midwives and a home-help service which functions for only a few hours each day on weekdays, no amount of effort by family doctors and district midwives will attract much support for home delivery. District midwives will have very few deliveries, perhaps not enough to maintain their skill, and much of their work will be postnatal care of patients delivered in hospitals, which may well be taken over by part-time midwives who do not attend deliveries.

Most of the hospital deliveries of the future will be in large district hospitals in which there may or may not be a few beds for the use of those general practitioners living close to the hospital. More than half the patients delivered in specialist hospitals will be normal and many will be used for pupil-midwife and medical student training under the supervision of midwives. Except where peripheral hospitals are retained, very few general practitioners will be able to attend their own patient in hospital, perhaps none where there are no general-practitioner beds in district hospitals.

Those general practitioners who wish to make good use of their special obstetric training may find that they are able to do so only if they are able and willing to take sessions as clinical assistants at specialist hospitals dealing with other doctors' patients under specialist supervision. The future may well show that in fact if not in intention it is for this that young doctors are being grained in obstetrics, not for the obstetric list and care of their own patients.

The service will be an efficient one, judged by the usual criteria of perinatal mortality and morbidity, and it will be satisfactory provided that the patient does not mind receiving antenatal and intranatal care from a variety of pupils, midwives, house surgeons, clinical assistants and specialists; if she is willing to attend clinics and go into the wards of hospitals miles away from her home, her relatives and her friends, and stay there for an arbitrary period regardless of her medical or social need.

The patient may wish to have continuity of care and personal attention from the doctor and midwife of her choice. She may wish to be under the care of a specialist only if her condition warrants attention by the specialist himself. She may wish to choose, without affecting her doctor's ability to attend her, whether she will be delivered at home or in hospital. If she chooses the latter she may wish it to be near her home and may wish to decide how long she will stay there. She may even wish to decide whether she will agree to be used for pupil or student training. A personal service of this sort will be available to very few. It could be arranged for the majority, but great changes in the direction of evolution of the maternity services will be needed and they will not easily be gained.

Two of the basic needs are already on the horizon, a large number of family doctors practising obstetrics and a midwife attached to each practice, so that doctor and midwife can work together, and so that there will not be so many deliveries under the care of each doctor that delivery will have to be left to the midwife alone. The cult of the independent midwife is fortunately declining; surely it has no future and must be discarded completely.

Other essential needs will be harder to gain, especially beds for family doctors not only in district hospitals but also in peripheral hospitals so situated that all doctors, and the midwives attached to their practices, have access. Specialists must allow normal cases to remain in the care of their family doctors, and the Central Midwives Board must agree that pupil midwives shall receive their practical instruction on cases occupying general-practitioner beds. Medical schools must make similar arrangements for students, and teaching must be carried on in the general-practitioner section of suitable district hospitals as well as in the specialist section. Teaching

departments in recent years have suffered from a dearth of general and private practice experience in their staffs and a great deal of good would come from an infusion of general-practitioner teachers. Midwifery services must be rearranged so that midwives can and will work in hospitals as well as on the district; so that district midwives have the same access to beds as the doctors to whose practices they are attached, and they must be provided with the necessary equipment and suitable transport. Local authorities, hospital boards and midwives must believe in the need for a general-practitioner maternity service, encourage the general practitioner to provide it and arrange their own services with this in mind.

If a personal maternity service of this sort were demanded by the ladies, and if their demands were strongly and persistently made, and organized, there is no doubt that it could be arranged in the fullness of time. An essential need is the enthusiasm of family doctors for maternity work, but of that there is no lack though it may be, especially at the present time, frustrated, concealed, unorganized and even, in some quarters, denied. What is lacking from family doctors is an association to put their idea of a maternity service with the same force as the Royal College of Obstetricians and Gynaecologists puts that of specialists and with singlemindedness equal to that with which the Central Midwives Board looks after midwives. Only when there are three organizations instead of the present two, can we expect a balanced service in which all three components play their proper parts.

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