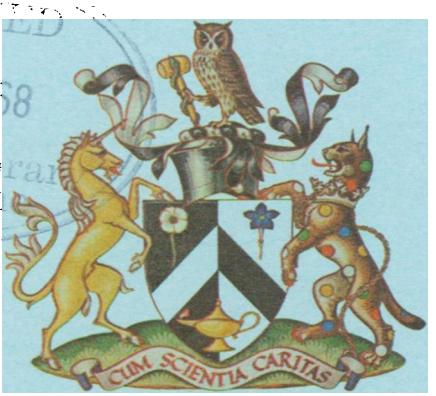
REPORTS FROM
GENERAL PRACTICE

IX

OBSTETRICS IN GENERAL PRACTICE

the report of a working party



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OBSTETRICS IN GENERAL PRACTICE

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CONTENTS

THE OBSTETRIC WORKING PARTY

MARGARET DUDLEY-BROWN, M.B., B.S., M.R.C.P., D.Obst.R.C.O.G., D.C.H. (York) (*Chairman*).

P. O'BRIEN, M.D., B.Ch., L.M. (Coombe) (Warrington) (*Honorary secretary*).

J. G. R. CLARKE, M.B., B.S., F.R.C.G.P. (Luton).

M. I. COOKSON, M.B., Ch.B., M.M.S.A., D.Obst.R.C.O.G. (Gloucester).

R. P. C. HANDFIELD-JONES, B.M., M.R.C.P., D.Obst.R.C.O.G. (Haddenham, Bucks.).

MARY HELLIER, M.B., Ch.B. (London).

LORNA HYLTON, M.R.C.S., L.R.C.P., D.C.H. (Clevedon, Somerset).

E. V. KUENSSBERG, M.B., Ch.B., F.R.C.G.P.

G. N. MARSH, M.B., B.S., D.C.H., D.Obst.R.C.O.G. (Stockton-on-Tees).

J. MCGLONE, M.B., Ch.B. (Glasgow).

C. H. STEWART-HESS, M.D., M.R.C.P. (Cheriton Fitzpayne, Devon).

ROMA CHAMBERLAIN, M.B., Ch.B., D.Obst.R.C.O.G., D.C.H. (*Observer*). Ministry of Health (London) formerly joint secretary Cranbrook Committee.

FOREWORD

ANNIS GILLIE, *D.B.E.*, F.R.C.P., F.R.C.G.P.

"Every family doctor is responsible for securing for his patients the best supervision and management of pregnancy, delivery and puerperium." (Field of work of the Family Doctor, 1963 para 52). A large but variable number of general practitioners obtain training in obstetrics with a view to management of normal cases throughout, and to secure integration in family care.

Fragmentation of the obstetric service has always existed. The tripartite form of the National Health Service has aggravated this. This fragmentation has probably persisted longer than in any other major division of medicine. But co-operation, alongside the lack of it, has survived. Contrasts were revealed in the Survey of Perinatal Mortality carried out in 1958 and published in 1963.

Now, five years later The Royal College of General Practitioners publishes its opinions on the role of general practice in the obstetric service, a role that is inescapable and with a potential for development in the interests of all concerned.

This report aims to face the issues of disagreement between the divisions of the three parts of the system. The report firmly maintains that "Placed as he is between the hospital and the domiciliary setting, ideally," the general-practitioner obstetrician "should be the co-ordinator of maternity services" (para 32) and only by recognizing this can true integration be secured.

That a critical and constructive discussion on this subject has taken so long to emerge from a general-practitioner body only reveals its significance. It emphasizes the value to the subject of a cool appraisal which would have been hard to achieve earlier when emotions could be high and clinical standards were variable. Such assessment required a study in the development of organization within practices and an experience of the importance of the general-practice team as an effective unity between family doctor and local authority medical staff—a union in work which can ensure competent management especially of the elements of irregular demand imposed by full obstetric care. Recognition of the general-practice obstetric team within general practice and within the obstetric service still remain to be achieved.

This report is also a result of renewed confidence in the part that

special obstetric training plays in the development of younger general practitioners and reveals in this their own assessment of the importance of obstetrics in family practice. The share the Royal College of Obstetricians and Gynaecologists takes in this is shown by the large number of present and future general practitioners who offer themselves annually for the Diploma examination. This in itself forms a bridge between the two groups of the profession who practise obstetrics, each with its differing range. The diplomates will constitute the majority of general practitioners of uncomplicated midwifery in the future if the role that they intend can be co-ordinated in the service to the benefit of all.

This report is presented with the conviction that existing difficulties can be solved if fully explored in a functionally unified service above sectional interests.

CONCLUSIONS AND RECOMMENDATIONS

1. The National Health Service by giving every expectant mother access to a doctor for maternity services introduced a new factor, the effects and benefits of which will not be fully apparent for at least a generation. *Para. 12.*
2. An important result of this change is the rapid increase in recent years in the number of new entrants into general practice who have taken vocational training in obstetrics. The eventual result will be that a large majority of general practitioners will be trained in obstetrics. They must be able to get placed on, and remain on, the obstetric list. *Para. 28–29, 84–86.*
3. Every general practitioner with special training should be admitted to the obstetric list. Special vocational training will be wasted if general practitioners do not have an adequate amount of maternity work. The aim should be to ensure that each of these is able to look after most of the maternity cases in his own practice and so retain his obstetric competence. *Para. 68, 84–86, 130.*
4. In the setting of general practice with a full supporting team and adequate facilities the majority of patients can enjoy a personal as well as an efficient service. The individual contract between general practitioner and expectant mother must be retained and stressed as a guarantee of personal interest. The one who can benefit most from this is the mother. *Para. 52, 114.*
5. The basic foundation of a maternity service is co-operation between midwife and doctor. Segregation of pupil midwives and medical students during training must be ended. In so far as uncomplicated cases are needed for training, it should be on cases under general-practitioner supervision with some general practitioners taking part in teaching. *Para. 43–45, 53–54, 65, 67, 129.*
6. A simpler unified administrative structure would be welcomed by most doctors and midwives. *Para. 104–106.*
7. Easy transfer of patients between general-practitioner and specialist teams is an essential feature of a good maternity service. Where there is full integration this presents no difficulty. *Para. 38.*
8. Provision must exist for continuing education of general-

practitioner obstetricians. Much will come from their own practices if they work in close contact with specialists. Short-term residential courses are needed especially for those who practise too far from a hospital to have access to beds. *Para. 75–83, 107.*

9. The majority of births in the future should take place in obstetric units. Home delivery, nevertheless, should be available for patients who are suitable for it, desire it, and have adequate homes. Every effort must be made to ensure the efficiency of domiciliary services. General practitioners and midwives responsible for domiciliary cases must, where possible, have an adequate amount of obstetric work, including attendance on patients from their district in obstetric units. *Para. 123–128.*

10. Beds must be so situated that as many general-practitioner obstetricians as possible have access to them. The ideal place for a general-practitioner unit is within the specialist maternity hospital. *Para. 113.*

11. Beds which are used for uncomplicated cases must be transferred to general-practitioner obstetricians wherever there are suitably trained practitioners willing to accept them. This means that a higher proportion of obstetric beds will be under the care of general-practitioner obstetricians. *Para. 32–33, 92.*

12. Local maternity liaison committees should constitute an important instrument to foster co-operation and to promote understanding, and should be a stepping stone to administrative integration. *Para. 58, 97–98, 107.*

I

EARLY HISTORY

1. IN THE nineteenth century, the general practitioner, successor to the apothecary, was also the obstetrician. In a few hospitals within or close to medical schools, specialists appeared who were reponsible for the more advanced work and also for teaching. To judge from the strictures of Florence Nightingale, when they first started to organize themselves into a corporate body towards the end of the century, midwives were trained badly or not at all.

2. From about 1830 most medical schools were teaching obstetrics. In 1845 the Society of Apothecaries introduced an examination in midwifery. The General Medical Council was founded in 1858, but it was not until 1886 that midwifery became a necessary subject for qualification under its regulations.

3. General practitioners were greatly concerned at that time about the lack of opportunity for adequate training in obstetrics. In 1888 a group of 337 petitioned the General Medical Council, providing support for that body's own pressure on the medical schools and examining bodies. It criticised "the very inadequate training in midwifery which had such harmful effects on the women of the country". Its recommendations included attendance by the student for six months at a maternity hospital, and his presence at 50 labours of which 30 should be personally conducted. In 1895 the British Medical Association undertook the leadership of this campaign.

4. The early years of the twentieth century saw profound changes which were gradually to put the family doctor farther and farther outside the field of obstetrics. In 1902 the first Midwives Act brought into being the Central Midwives Board and entrusted supervision of midwives to local authorities. In 1911 the National Insurance Act introduced 'panel practice' for general practitioners. Maternity benefit first appeared under this legislation at a rate of 30s. 0d. but this was for the services of the midwife and specifically excluded any right to attendance or treatment by a doctor. The cleavage between general practice and midwifery had effectively begun.

5. Nineteen-eighteen saw the passage of the Maternity and Child Welfare Act and the second Midwives Act. The first of these gave to local authorities powers which enabled them to set up antenatal clinics, which appeared all over the country and were staffed usually

by full-time medical officers. The Midwives Act made it compulsory, when an abnormality occurred, for a midwife to summon medical aid directly; this service to be paid for by the local authority, who could claim from the patient.

6. At this time a number of voluntary hospitals, mostly in the teaching centres, ran their own domiciliary service in the surrounding district. In 1929 the Local Government Act transferred the management of poor law institutions to local authorities; large and efficient maternity departments in municipal hospitals and in some places separate maternity hospitals began to appear.

7. This gradually brought about an increase in hospital deliveries from 15 per cent in 1927 to about 40 per cent in 1937, depending on what was deemed to constitute a hospital delivery. With the advent of the National Health Service many private maternity homes disappeared and also the statistics became more accurate; by 1957 the rate was 65 per cent for all institutional deliveries and in 1966 it was 75 per cent. The provisional figure for 1967 is 77 per cent.

8. In 1929, surgeons specializing in gynaecology and obstetrics decided to organize themselves and founded the British College of Obstetricians and Gynaecologists. This foundation, with its surgical bias put the general practitioner engaged in obstetrics at a further disadvantage whilst it provided for the combined specialty a strong and resolute leadership.

9. In 1934 the Central Midwives Board advised midwives to offer their patients two antenatal examinations by a doctor; this further stimulated the growth of the local authority clinic. Just before the National Health Service was introduced about three out of four expectant mothers attended these clinics, but even then one in six was looked after solely by the midwife. It is interesting to reflect what were then the accepted norms for practice by the midwife. Before 1937, according to the Central Midwives Board rule book, she could, for instance, legitimately look after a patient with toxaemia until albuminuria appeared or a breech delivery until the head was held up by an incompletely dilated cervix.

10. The rules for pupil midwife training unintentionally encouraged exclusion of the doctor, lest the case should be spoiled for the pupil. This fostered in the pupil, once she was fledged, a pride in her ability to do without medical aid. Finally, there was the unfortunate distinction made in reference to the midwife working in conjunction with a doctor—by this very fact she became a 'maternity nurse'—a much more lowly creature in her own esteem and that of her colleagues. (This term has quite a different connotation today.)

11. In 1936 the third Midwives Act brought into being the whole-time municipal midwife who received no direct payment from her

patient. The local authority now had power to provide a comprehensive midwifery service, but rarely arranged for an expectant mother to be under the care of her general practitioner unless an abnormality developed.

II

CHANGES INTRODUCED WITH THE NATIONAL HEALTH SERVICE

12. One of the fundamental changes introduced with the National Health Service in 1948 was the provision that an expectant mother could contract for maternity services with a general practitioner, free from the burden of direct payment. In most cases this would be her own family doctor but where he did not provide this service she could choose another practitioner from the 'obstetric list'. Initially, this was a list of those doctors, established in practice, who elected to provide maternity services, but the intention was that ultimately it should be a list of doctors who had prepared themselves for the role by adequate vocational training.

13. A tradition that midwifery is a corner-stone of family practice was still strong, in spite of many setbacks. Maternity service within the new setting is not a part of general medical services, although both are administered by executive councils. A unique feature of this maternity service is that in every case a specific contract is made between the expectant mother and the doctor she has chosen, and is signed by both parties. This places the doctor in a position of considerable responsibility; he must provide all necessary services throughout pregnancy, labour and the puerperium or make adequate arrangements for their provision on his behalf. It is an important guarantee for mother and doctor.

14. The extent of this responsibility has become clearer as the service has evolved. At the outset it was laid down that at least two antenatal examinations must be carried out. Later, when some of the short-comings of the service came to be appreciated, more rigorous criteria were laid down; for a short time great detail was required when a claim for services was submitted to the executive council. This provoked a strong reaction from many doctors who felt that an excessive proportion of their working time was already

being expended in clerical chores to the detriment of clinical work. The obligation to provide such detail was withdrawn, but the expectation of higher standards had been established, and it had emerged that many doctors were providing antenatal care of a good standard, with a high frequency of examination.

15. The clearest exposition of the role of the general-practitioner obstetrician came in a memorandum from the Ministry of Health in 1962 which states that: ". . . a practitioner who has arranged to provide maternity medical services for a person *shall be responsible for arranging that the person receives all necessary medical services during pregnancy, confinement and the postnatal period . . .*" Exceptions are set out in detail, but the statement leaves no doubt about the obligations of the practitioner who makes this contract; he is not obliged to do everything himself but his *overall responsibility* is stressed.

16. In the early days of the National Health Service there were many factors operating against implementation of those changes which had been decreed by legislation. The forces of reaction were strong and older patterns persisted for many years. General practice itself was not ready for the profound change in maternity services. Doctors were just recovering from the upheaval of the war years; their main concern was with the new pattern of general medical services. Among established practitioners many had been cut off from obstetrics for so long that the knowledge and expertise which they once possessed had atrophied.

17. Many of those who had been engaged in active obstetric practice welcomed the new opportunity, but their training had been mainly in the heroic midwifery of the "medical aid" era. Some failed to appreciate the chance they were being given to provide comprehensive antenatal care, with a guarantee that the hospital service would accept the complicated cases which they were now enabled to select in advance. Others perceived that this was a service in which they could find fulfilment.

18. Younger doctors had been recently trained in a discipline which now stressed the importance of high-grade antenatal care. The future was with them, but some became moulded to a greater or lesser extent by circumstances and by the established patterns of those among whom they came to work. Gradually, however, as new entrants increased so did the pressure for enlightened progress.

19. The midwife who had been encouraged in her sturdy independance was alarmed and confused. Collings (1950) recorded the poor relationship, sometimes amounting to open hositility, which existed between midwife and doctor in those early years. Here again change

was gradual and patchy. Where the doctor was seen to provide a good quality service he usually convinced the midwife that he was a friend and ally who could strengthen her position, providing her with reliable backing without, at the same time, displacing her in her cherished function—the normal delivery.

20. The specialist obstetricians were those in the strongest position. They had looked to the future and had made a realistic appraisal (1944 Report). Their Royal College had predicted a service in which—"general practitioners should take an important share", but it should be restricted to those with special experience. This should mean at least a six months resident hospital post after qualification; in addition it was recommended that the young doctor should take the examination for their diploma in obstetrics. The same report criticized local authority antenatal clinics which provided "antenatal care isolated from the management of labour", and suggested that the doctor who saw only one aspect of obstetrics tended "to become a mere routinist" whereas "continuing supervision" should be the aim. The best of domiciliary midwifery was praised, with the added recommendation that it should be a continuing feature of the service; its success would be guaranteed by three factors; a high standard of antenatal care, effective case selection and a firm backing from the consultant and hospital services.

III

DEVELOPMENTS SINCE 1948

21. It soon became evident that the various elements comprising the new maternity service were failing to coalesce. The Gillebaud Committee in 1955, blamed tripartite administration and recommended an early review of the organization of the maternity services. As a result the *Cranbrook Committee* (England and Wales) and the *Montgomery Committee* (Scotland) were set up; these reported in 1959. They provided a masterly review and a sound analysis with some good recommendations, but positive benefits have been slow to emerge. Maternity liaison committees which first appeared as a result of the Memorandum on Toxaemia, were given a new lease of life, and obstetric co-operation cards were brought into being. These reports shifted the blame from divided administration to failure of co-operation between medical personnel.

22. Examination and re-assessment was also proceeding in other

ways. The *Confidential Enquiries into Maternal Mortality* initiated in the late 20's had gradually decreased. In the early 50's they took on a new form, and reports have been issued for each period of three years since then. The investigations have been detailed and cover about 80 per cent of all maternal deaths. The principal aim is to identify avoidable factors. A gradual improvement in standards of care in all sectors has been demonstrated in successive reports.

23. In 1958 the National Birthday Trust Fund carried out a short but intensive survey of *Perinatal Mortality*. A report on this was published by Bonham and Butler in 1963. This showed up many faults in the service but it also served to demonstrate advances, for instance that a high standard of antenatal care was being provided by many family doctors well in excess of the specified minimum. Whereas the general-practitioner obstetrician was obliged to carry out a minimum of only two antenatal examinations to claim his fee, it was shown that his average was nine. Those mothers who were being attended by both general-practitioner obstetrician and midwife had an average of 14 attendances, higher than any other group (figure 1). When analysis was made it was found that in the

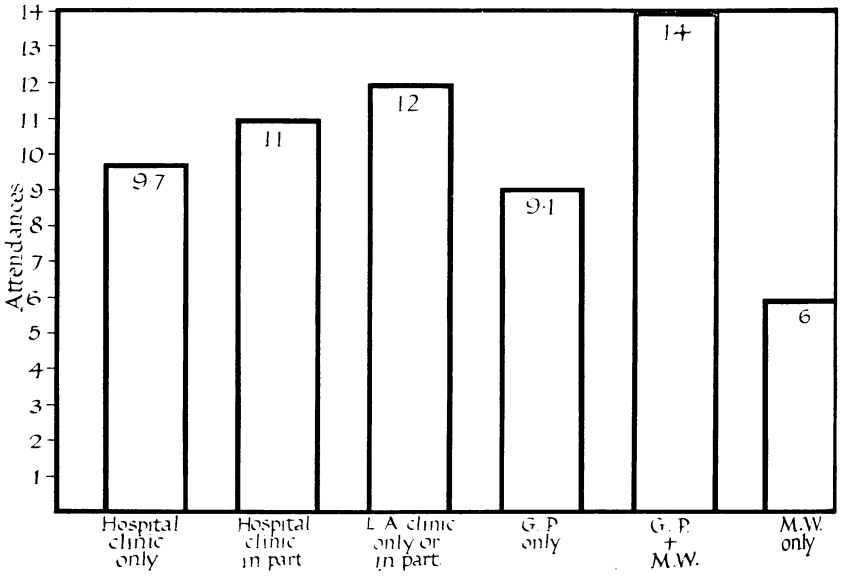

Figure 1.

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

(*Source:* Cookson—Gale Memorial Lecture, fig. 2). *J. roy. Coll. gen. Practit.* (1967), **13**, p. 154

great majority of cases the senior person present at delivery was the midwife and next in order came the general practitioner (figure 2).

Incidence in Population.

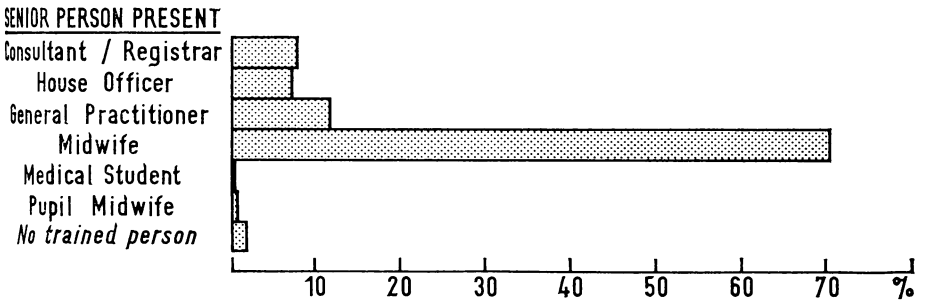

Figure 2.

Senior person present: Consultant/Registrar House Officer General Practitioner Midwife Medical Student Pupil Midwife No trained person (*Source:* Perinatal Mortality Survey, fig. 49, 1.)

24. Maternity teaching hospitals have a long tradition of careful accountancy and analysis of results. This habit spread to some of the peripheral hospitals, but there was little attempt to look at the results for whole communities, except in the Oxford region with its Area Department of Obstetrics where integrated services had been an early feature.

25. It was not appreciated until the second decade of the National Health Service that the general-practitioner obstetrician could also make a useful contribution to obstetric accountancy. The lapse of time was due to the fact that it required at least ten years for individual doctors and some partnerships to amass enough records to provide a valid analysis, but since 1960 a steady flow of these reviews from general practice has been maintained (O'Brien 1963). A collective review of their obstetric practice during 12 months was carried out by 116 general practitioners in the South-west of England in 1954–55; the analysis was published in 1957. Shortly afterwards a survey of *General Practice Midwifery* in Scotland based on replies from 162 doctors regarding their "experience, qualifications, procedures and problems in domiciliary midwifery" was published (Kuenssberg and Sklaroff, 1958).

26. In 1962 the Royal College of Obstetricians and Gynaecologists published its views on general-practitioner maternity units. This report seemed to reveal an underlying distrust of the general-practitioner obstetrician; it set out a catalogue of exclusions which

would ensure that this doctor would have little more responsibility than a midwife.

27. *The Gillie Committee* in 1963 provided a lucid analysis of the main features necessary for a good general-practitioner obstetric service, including adequate provision of hospital beds, proper selection for hospital and domiciliary delivery, good supporting services in the home and a constant review of effectiveness.

The present

28. Since 1948 each branch of this service has adapted itself to the new conditions; the general-practitioner obstetrician has changed more than any of the others except the local authority medical officer who in many places has ceased to take part in antenatal clinics. The greatest change in general-practitioner obstetrics is in the number of new entrants who have had special training in obstetrics. The Diploma in Obstetrics of the Royal College of Obstetricians and Gynaecologists (intended for general practitioners) is now awarded to nearly 700 candidates a year. Not all go into general practice but many do. For instance the position in 1965 of those awarded the diploma in 1955 is shown in table I.

TABLE I

THE EMPLOYMENT IN 1965 OF 349 DOCTORS WHO TOOK THE D.R.C.O.G. IN 1955

	Number	*Percentage*	*Percentage of those traced*
General-practitioner in U.K. ..	167	*47·7*	*57·2*
Consultant, registrar or S.H.O.	48	*14*	*16·4*
Public health and industry ..	25	*7*	*8·5*
Abroad, including Eire ..	51	*15*	*17·4*
Not in practice	1	*0·3*	*0·3*
Not traced	57	*16*	—
D(Obst) R.C.O.G. 1955 ..	349	*100*	

29. If the proportion of diplomates entering general practice in 1967 is the same as in 1955, about 50 per cent of new entrants will hold the diploma. The proportion of new entrants in the Gloucester Executive Council area holding the diploma was 43 per cent for those who qualified in 1959–1962, and an additional 32 per cent had been obstetric house-surgeons but did not hold the diploma (Cookson 1967).

30. There has been a marked rise in the numbers awarded the Diploma in Obstetrics (D.Obst. R.C.O.G.) from 1946 to the present

(figure 3). The Macafee Report (1967) states: "From the number ... who offer themselves for the diploma examination (800–900 per annum) it appears that there is a strong desire among general practitioners to take an active part in the maternity service". This trend, which will lead to a large increase in the number of trained general-practitioner obstetricians is not as yet matched by a similar increase in the proportion of general-practitioner maternity beds of which there were 4,428 in 1966 compared with 17,581 specialist beds (78 per cent of the total).

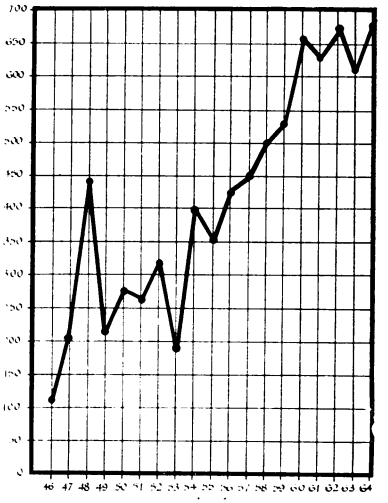

Figure 3.
The number of diplomas awarded each year 1946 to 1964 by the Royal College of Obstetricians and Gynaecologists. (*Source:* Cookson, fig. 4)

31. Consultants find difficulty in teaching their junior staff because they are overwhelmed by the requirements of routine care which has limited teaching value (Macafee Report 1967). This situation arises from general practitioners' lack of beds. Delivery of straightforward cases in specialist hospitals may lead again to delegation of antenatal care to doctors who have no responsibility for delivery, thus reintroducing one of the worst features of the local authority antenatal clinics which the Royal College of Obstetricians has condemned (1944).

IV

THE GENERAL-PRACTICE TEAM WITHIN THE MATERNITY SERVICE

32. *The potential value of the general practitioner to obstetrics* will depend on the extent of his special training, his subsequent experience and the opportunities and facilities available for him to put his training into practice and maintain his skills. Providing he is

properly trained and has good facilities the majority of obstetrics is within the province of the family doctor. Placed as he is between the hospital and the domiciliary setting, ideally, he should be the co-ordinator of maternity services.

33. At present many general-practitioner obstetricians lack the necessary facilities (i.e. beds and a supporting team in the practice) so that much straightforward obstetrics is being conducted quite unnecessarily in specialist units. At a time when delegation of appropriate tasks to less highly-trained personnel is common policy, in order that the community shall enjoy the greatest benefit from its limited resources in medical manpower, the specialist should be relieved from supervising uncomplicated cases. This view the Royal College of Obstetricians endorsed in 1967.

34. *The definition of normal midwifery* is a problem. It is not clear cut, nor can it be; what is considered normal will vary with time, place and other circumstances. A spontaneous delivery may be predicted following a normal pregnancy, but it is only in retrospect that normality can be confirmed or refuted. Baird (1960) says of the family doctor who has had adequate vocational training for obstetrics that—"he should be competent to repair a torn perineum, deliver with forceps, and remove the placenta manually". Is this normal midwifery? Not all who are responsible for the administration of general-practitioner maternity units would accept that it is, yet these are procedures which are still carried out by general practitioners even in domiciliary practice.

35. However normality is defined, the practitioner should never knowingly allow a situation to develop beyond the point at which he has the skill or facilities to deal with it. He owes it to his patient and to his specialist colleagues that he should seek advice and assistance when such a situation is still only a possibility. Jameson and Handfield-Jones (1954) reporting on general-practitioner obstetrics in a cottage hospital, enunciated the principle that "The practitioner must realize his own limitations and those of the setting in which he works; for if any abnormality arises which he cannot safely tackle, it is his duty to his patient to ensure that she is sent to expert hands in good condition".

36. *The relationship between the general-practitioner obstetrician and the consultant* is one of the major problems of this service. It varies greatly from place to place. There may be an element of personality in these variations, but the problem is wider than this. Many of the present difficulties may be attributed to the fact that there has never been a discussion of policy at top level between representatives of these two groups. Many consultants are only prepared to work in a service with general-practitioner obstetricians

if they can lay down and apply strict rules of practice. Many general practitioners would only be prepared to work in a unified service if they could enjoy unfettered clinical responsibility. A solution of these difficulties can only result from dialogue which is based on mutual understanding, respect and trust.

37. Godber (1963) in commending the results from the Oxford Area Department of Obstetrics, made the point that: "Specialization . . . will not succeed by trying itself to provide the whole of the maternity services. Specialists as their expertise advances, depend more on being used and properly used—by others . . . successful specialization in obstetrics leads to partnership, not monopoly in the maternity services". The Royal College of Obstetricians in its 1962 report commented on the problem from a different angle: "If consultants are not consulted by general-practitioner obstetricians, or if consultants interfere arbitrarily in the clinical care which a general practitioner affords his patient, good relations are jeopardized and liaison breaks down".

38. There should be an easy two-way flow of cases between the general-practitioner obstetrician and the specialist; when the general practitioner is confronted with complications he should have no hesitation in calling on the specialist and in transferring the patient temporarily to his care; when the complications are past, resolved or overcome, the specialist should have no hestiation in sending his patient back to the general-practitioner obstetrician.

39. As in other departments of medicine the general-practitioner obstetrician must decide when to seek another opinion. He must however regard himself as a member of a team, with an obligation of professional loyalty to the team as a whole, and remembering that his consultant colleague is ultimately at risk for any case that develops complications.

40. Growing experience, a good record, and a high standard of work should earn for the general-practitioner obstetrician greater latitude to extend the degree of personal responsibility within mutually accepted limits. There is a parallel in the way in which American doctors become accredited, and gain and maintain their hospital privileges in various specialties.

41. In addition to the complete care of straightforward cases the general-practitioner obstetrician should provide much of the antenatal and postnatal care for the complicated cases from his own practice booked for delivery in a specialist unit. This is already an accepted practice in some areas. It is undesirable for doctors who hold no responsibility for deliveries to conduct antenatal clinics. This applies whether it be for whole-time general-practitioners or for other doctors employed part-time (as suggested in the Macafee

Report). Such a retrograde step would bring back one of the least desirable features of local authority maternity clinics.

42. It is to the advantage of mothers if the family doctor conducts the postnatal examination, since the next step in any further gynaecological care will be his to take. Also, it provides a useful opportunity to advise on family planning and to screen the child-bearing population for carcinoma of the cervix.

The general-practice team

43. (*1*) *Midwives.* The steady decline in domiciliary obstetrics makes it difficult to predict the role of the midwife outside hospital and she feels frustrated. Those in domiciliary practice feel their work lacks fulfilment when much of their time is spent in nursing mothers and babies delivered in hospital. The hospital midwife also feels frustrated at what is sometimes cynically described as the 'mass-production, conveyor-belt' atmosphere which has resulted from the adoption of short stay with early discharge. A novel solution which is being tried in some places is for the domiciliary midwife to follow her patient into hospital for delivery and then care for her at home throughout the puerperium. It seems that the local authority component in this service will in future play a much less conspicuous and direct part, which would be a sensible arrangement. It has become much more common to attach midwives to doctors, especially in group practices.

44. However these problems are to be resolved doctors and midwives who have been learning to work together much more closely and amicably over the years must not allow a new rift to develop. This gradual development of co-operation is exemplified in a statement of Stewart-Hess and Green (1962) which says: "The management of spontaneous delivery has become increasingly the prerogative of the midwife during the 11 years of this study and rightly so. Our realization of this fact, whilst remaining in full control of the case, has developed slowly. . . ."

45. All obstetricians, whether specialist or general practitioner must bear in mind that in Britain the majority of normal deliveries are conducted by the midwife no matter who else is in attendance. The present equilibrium has been reached slowly and sometimes with difficulty. We must do everything in our power to resolve present problems so that recruitment of midwives is not adversely affected.

46. (*2*) *Health visitors* should be attached to all practices and this is gradually happening. They should work in the doctors' premises, in the people's homes, and should have access to the hospitals. Their work will include health education in the broadest sense; mother-

craft classes and classes for fathers; with instruction in hygiene and baby care including breast-feeding.

47. (*3*) *Physiotherapists* can provide relaxation classes and instruction in postnatal exercises at an appropriate centre in or outside the hospital. Dietary instruction from a qualified *dietician* can be similarly arranged. However, in many instances the health visitor and the midwife can and do provide much of these skills.

48. (*4*) *Clinical assistance.* Nurses or suitably-trained lay personnel should be employed to test urine, estimate blood pressure, weigh patients, take blood and estimate haemoglobin levels (using a reliable method). In whatever way these are provided the doctor must have direct access to modern diagnostic facilities; where his practice is at a distance from the laboratory, an organized collecting service for specimens is valuable, though a postal service can supply the needs of many practices.

49 (*5*) *Clerical assistance.* Good secretarial help is essential to an efficient and modern practice, with up-to-date facilities for recording, filing and intercommunication. The *secretary* will be responsible for record keeping, both routine and for research; for the completion of forms; and for all correspondence. The *receptionist* will be responsible for the smooth running of clinics and for booking advance appointments.

50. *The general practitioner as anaesthetist.* The general practitioner should only administer a general anaesthetic in exceptional circumstances, unless he has had special training and is experienced. Anaesthesia for obstetrics is no longer the problem it has been in the past; modern methods using a local anaesthetic reinforced with analgesic and sedative drugs will permit many procedures to be undertaken in comfort, and with greater safety, which were considered formerly to require a general anaesthetic.

51. *Potential value of the general practitioner to his patient.* General-practice obstetrics implies continuing, comprehensive and personal care of the mother and her baby. With his intimate knowledge of the mother, her family and her circumstances, the family doctor can provide greater support for morale than any other doctor or agency. Pregnancy and child-bearing are times of considerable stress for many women. Cared for by a general practitioner, they are likely to find greater understanding of, and more adequate treatment for many of the ills, not specifically obstetric, which may arise at this time and can be an additional burden.

52. During the period of antenatal care the doctor builds up a special relationship with his patient; she comes to regard him as a particular symbol of her safety and well-being. For this reason it is important for her that the doctor should be present when she is in

studied by maternity liaison committees and all who are interested in future planning of the obstetric services.

59. There is a good deal of confusion, duplication and overlap in *obstetric records*, but the obstetric co-operation card which was introduced a few years ago by the Ministry of Health and is in use in most parts of the country is a step in the right direction; it is a useful and practical means of record linkage between the various agents concerned. If the patient carries this card and if it has been properly written up there should be no mishaps from lack of information. This card should be the standard record and its use obligatory where any part of obstetric care is shared.

60. *Other hospital roles for the general-practitioner obstetrician.* In places where most general practitioners are engaged in normal obstetrics with adequate provision of hospital beds there will be little opportunity for any of them to be employed as clinical assistants or in the medical-assistant grade (Platt Report, 1961).

61. In maternity units which cater for mothers from a considerable distance and whose own family doctor will be precluded from attending for this reason, clinical assistant posts might well be developed to relieve the specialist staff of the extra burden of uncomplicated cases. There is also the possibility in these circumstances, that the family doctor would arrange with a general-practitioner obstetrician living nearer to the unit to look after his patient within the normal framework of general-practitioner obstetrics.

An alternative service

62. Three-quarters of all general practitioners are on the obstetric list and approximately the same proportion of new entrants into general practice have trained in and will wish to practise obstetrics. If this trend continues the list will remain at about its present size but consist eventually only of doctors with special training. In practice the situation is flexible and the future will show the extent to which individual doctors take responsibility for the maternity cases in their practices or allow one or two members of a group to do so. It is probable that most general practitioners will wish to take their full share in maternity work.

63. It follows that in large groups in which responsibility for obstetrics rests on a few members who limit their commitments in general medicine, those doctors can become much more experienced in obstetrics than the average general-practitioner obstetrician, and acquire special skills. Where it exists, special skill should be recognized and used. Those capable of dealing with abnormalities should do so in general-practitioner units, where the provisions are suitable. They should be eligible to work in the specialist unit in the medical assistant or other suitable grades. On the other hand, specialization

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within groups must not prevent general-practitioner obstetricians who wish to do so from providing maternity services for their own patients.

V

TRAINING AND QUALIFICATIONS OF THE GENERAL-PRACTITIONER OBSTETRICIAN

1. Undergraduate training

64. Undergraduate training should continue as at present with emphasis on basic principles and obstetrics should continue to feature in the qualifying examination for all doctors. Antenatal and postnatal clinics should be attended; there should be emphasis on childbearing in its social setting and in relation to physique and environment as well as health and disease. All general practitioners must, at times, deal with illness in pregnant women; basic obstetric training is essential even for those not intending to practise obstetrics.

65. In addition to his training at a teaching hospital, it is desirable that the student should spend a period in residence at a district maternity hospital having general-practitioner as well as specialist beds. He should conduct a small number of deliveries himself, and observe a much larger number consisting of a few abnormal deliveries conducted by specialists and many normal deliveries conducted by pupils or midwives under general-practitioner surveillance. In this way he will learn the part played by a doctor at the delivery of those mothers for whom a general practitioner takes responsibility.

66. Emphasis should be on recognition and observation of the normal and early detection of abnormality. The scope of training will require modification as obstetrics develops; at present it should include the management of labour, normal delivery, local anaesthesia, episiotomy, perineal repair, analgesia, transfusion and resuscitation. It should also include the care of the new born, especially the premature, and recognition of congenital abnormalities.

67. Medical students and pupil midwives should be taught on the same cases. Emphasis should be placed on the mother's need of both doctor and midwife. It is important that students should spend

many hours with mothers in labour at all stages, and not only witness deliveries.

2. Vocational training

68. Vocational training is needed to supplement the basic training of the undergraduate so that he is competent to provide maternity services in general practice without supervision. As his competence will greatly depend on the use he makes of specialist support, he should be taught to distinguish between cases which he can deal with himself and cases needing specialist attention. He should be encouraged to take an interest in, and given time for, record keeping; in the statistical evaluation of results: and in the application of this knowledge to decisions he must make regarding the care of individual patients.

69. The first part of vocational training should be six months as house surgeon in a specialist maternity hospital where he may become conversant with those treatments which require specialist skill and the types of case likely to benefit from it. He will acquire more skill in dealing with minor abnormalities such as perineal repair and he should learn simple techniques such as low forceps delivery and manual removal of the placenta.

70. Time should be spent in studying care and resuscitation of the newborn with emphasis on feeding problems and on management of the premature baby. Attention must also be given to the recognition and management of congenital defects, especially those where early treatment is imperative if the infant is to develop to its full capacity.

71. The training period should include attendance at a gynaecological outpatient department for one session each week.

72. Training for general-practice obstetrics is not complete until the doctor has conducted in general practice deliveries under supervision at home or in general-practitioner units in hospital. In some areas in the future, it may be rare to find any domiciliary obstetrics, but where it does persist the trainee should be encouraged to gain experience in this setting which encourages good organization, planning and resourcefulness. All this should be an integral part of his vocational training before undertaking provision of maternity services on his own responsibility.

73. The specialist obstetric team relies heavily for its junior resident staff on young doctors destined for general practice who take these posts precisely because they want vocational training to equip them for obstetrics in their own future practices. If general practice were to lose its obstetric component for any reason, then obstetrics would lose not only the contribution of established practitioners but also a large part of its supply of resident staff.

74. Any test of vocational training for general practice should include obstetrics, this test to be modified in the case of those doctors who have stated that they have no intention of practising obstetrics and who may wish to devote more of their time at this stage to other facets of general practice which are of greater interest to them.

3. Continuing education

75. Those who have been responsible for arranging courses for established general practitioners in recent years, including this College, have been impressed by the great demand for courses in obstetrics. When these are offered they attract very substantial support. This is further evidence that many general practitioners not only wish to engage in obstetrics but want to do it well.

76. Every general practitioner who is suitably trained and wishes to do so must be given the opportunity to provide maternity services for the patients in his practice, and he should attend the deliveries of patients he has supervised during the antenatal period. A doctor dealing with the maternity work of an average practice, who has access to general-practitioner beds near or within a specialist hospital and has good liaison with his specialist colleagues will thereby be provided with an important part of his needs for continuing education in this subject.

77. Not all general practitioners will be able to work in close association with a specialist hospital and some may not have access to obstetric beds. Some who work in isolated areas may deal with only a small number of cases and yet must, of necessity, be obstetricians. These will be mainly dependant on special arrangements for continuing education.

78. More provision must be made for residential and non-residential courses, for clinical assistantships which are educational rather than service appointments, also for short-term exchanges between doctors on hospital staffs and general practitioners. Such exchanges can be valuable in providing an opportunity for the specialist-in-training to have some first-hand experience of problems as they present outside hospital, as well as helping to provide cover for the general practitioner in the period away from his practice.

79. The use of obstetric beds for educational purposes should not interfere with the facilities afforded to local general-practitioner obstetricians; some of these will have a contribution to make to the teaching programme.

80. In a maternity service in which a large number of general practitioners take part, each dealing with his own patients, adequate continuing experience in techniques such as forceps delivery will

not be possible for all. Increasing development of group practice will enable groups to arrange for one or two of their members to retain skill in special techniques by dealing with appropriate cases for all members of the group.

81. Evaluation and control of standards of practice depend on record keeping and analysis of results for all patients in a community whether delivery is in the home or in a general-practitioner or specialist hospital. The mechanics of record collection and analysis should be the responsibility of the hospital boards, but general practitioners who will be responsible for the majority of deliveries, must take an active part in planning and in assessment of results. There should be regular meetings attended by specialists, general practitioners and midwives, at which results and policy should be discussed. These constitute a most valuable educational exercise. Case conferences can be of considerable benefit; and in these the general-practitioner obstetrician should take an active part. Active participation is a greater stimulus and the preparation of material is a valuable exercise in itself.

82. Each region should establish postgraduate teaching departments for obstetrics. These should not be at or near an undergraduate teaching department, but at district hospitals associated with general-practitioner maternity units in residential areas where there is a large volume of abnormal obstetrics. These centres should provide residential courses for doctors from a distance, and non-residential courses, seminars, conferences and less formal meetings for those living close at hand.

83. The director of a regional postgraduate training centre could be either a consultant or a general practitioner; he should have a staff, including general-practitioner obstetricians with adequate time for teaching as well as carrying out the obstetric work of the centre. Senior registrars should spend a considerable part of their training period, especially that immediately preceding appointment as consultant, at regional postgraduate training centres, rather than at an undergraduate training department, for it is at the former that they will be brought into close contact with general practitioners with whom as consultants they will have to work in close association.

*4. The obstetric list**

84. The obstetric list of doctors able and willing to provide maternity services should be retained. Admission to it should be attainable by any general practitioner following adequate vocational training in hospital and general practice. There should no longer

*England and Wales.

be any means of securing admission to the list with less than the approved standard of training.

85. The aim of restricting the obsteric list to doctors with special training and continuing experience in obstetrics should be accomplished gradually, by controlling admission to it through local obstetric committees and by ensuring that an adequate amount of obstetric work is available to all trained general-practitioner obstetricians by providing them with access to beds. There should be no criteria for removal from the obstetric list of a trained general-practitioner obstetrician other than proven incompetence or malpraxis. Persistent failure to maintain an acceptable standard could be dealt with by a case review committee of general practitioners and consultants.

86. These provisions should eliminate the need for controlling the activities of less well trained or less experienced practitioners through a lower rate of remuneration, as we have had since 1948.

VI

GEOGRAPHICAL AND OTHER SPECIAL PROBLEMS

87. Variations in community patterns and attitudes produce striking variations throughout the U.K. so that it is quite impossible to produce one standard pattern of service for all. The following are some of the outstanding problems.

Birth rate

88. This is an important variable which must constantly be taken into account in planning. At present there is a decline in birth rate which, with the advent of oral and other newer methods of contraception, may be expected to continue. As opposed to this, the sharp increase in birth rate in the years immediately following the last war is now bringing about an increase in the number of potentially fertile marriages; consequently the total number of births may, in the immediate future, more than offset the present decline in birth rate. The rate is necessarily higher in new towns and new housing estates, in contrast to slum areas in older towns where it is often low.

New towns

89. The development of obstetric services in new towns has not

followed a consistent pattern. Until recently the provision of medical services has been haphazard. Maternity beds have not been provided at an early stage, or if provided are not in sufficiently close relationship to the district hospital, thus they lack the ready access to supporting specialist services which is desirable.

90. New towns have a high ratio of couples of childbearing age, consequently the birth rate in them is higher than the national average and will fall slowly. Provision for the immediate future must rely on a policy of early discharge, rather than a large increase in maternity beds. Young families in new towns lack the support of relatives who often live at a distance, hence supporting personnel (midwives, home nurses, health visitors and home helps) must be available in adequate numbers.

91. The Dutch system of providing 'maternity aids' has been considered and discussed many times in recent years often with a feeling of envy. These aids are specially trained for their task and are highly prized in a country which has an unusually high rate of domiciliary midwifery. They are resident with the family during their period of service, which would not be feasible in many of our homes. There is room for experiment, however, and it should be possible to produce a domiciliary-maternity-assistant something between our present home help and the Dutch maternity-aid.

92. Close co-operation between hopsital, local authority, and general practice is essential both in the planning stages and in operation. Interchange of domiciliary and hospital midwives might well promote greater understanding; it would provide a new form of continuing education; alleviate temporary staffing difficulties; and lessen the objections to early discharge. Adequate provision of beds for abnormal cases in the care of specialists must be made. If, in addition, an increase in beds for uncomplicated cases is desirable these should be in the care of general-practitioner obstetricians.

93. In the new towns a domiciliary obstetric service would have the advantage of modern housing but against this there are many social disadvantages. Adequate provision of maternity beds should enjoy early priority and must be supported by good diagnostic facilities, such as are planned for the policlinic shortly to be established in the new town of Runcorn.

Large towns and the conurbations

94. Maternity services in these have been hampered in the past by problems of poverty, bad housing, poor santitation, and high population density. This has resulted in a marked demand for greater provision of hospital obstetric services. Poverty and insanitary living-conditions have also resulted in a high incidence

of obstetric complications with high perinatal and infant mortality (cf. Smith and McDonald 1965). Latterly a rise in living standards and greater public understanding of the need for antenatal care have improved this situation. Now only a small proportion of cases (25 per cent or less) require specialist attention (Royal College of Obstetricians and Gynaecologists, 1967); the remainder are suitable for delivery under general-practitioner care.

95. In many of these areas the decline in domiciliary midwifery, coupled with the exclusion of the family doctor from hospital services, has led to a decline in general-practitioner obstetrics which is both quantitative and qualitative. Since consultant obstetricians now wish to shed much of the load of routine care in uncomplicated cases ways must be found of building up this service again. In some of these areas the initial solution will be for a small proportion of general practitioners to undertake the bulk of obstetric practice. In others the large majority of general practitioners will wish to increase their obstetric work if the opportunity presents. Certainly the great majority of the new recruits to general practice will be trained for obstetrics and will expect to practise it. Local maternity liaison committees should be utilized at an early date to explore these possibilities and to present plans.

96. Local maternity liaison committees were originally set up to consider the memorandum on "Ante-Natal Care Related to Toxaemia" (1956). In most areas they then lapsed until the Ministry of Health encouraged their re-establishment in 1959 following the recommendations of the Cranbrook Report. Some places (e.g. Ipswich) already had them much earlier because they had arisen of necessity to resolve some acute local problem. These liaison committees represent all the local professional interests in the maternity services. They discuss matters referred to them on behalf of the hospital management committee, the executive council, the local health committee, the local medical committee and others. They confer on matters of policy, then make their recommendations to these other bodies or sometimes directly to the practitioners concerned.

97. There are still many areas which in practice do not have a liaison committee. This would seem to indicate a failure in communication and co-operation although in some instances it could infer that good working relations have already been established, thus lessening the need for yet another committee.

Scattered rural population

98. The special problems of rural areas are attributable to long distances, poor communications and difficult access liable to sudden deterioration due to bad weather conditions or seasonal influx of

extra traffic on the roads. The tradition of domiciliary midwifery is strong; nevertheless, in recent years there has been a tendency in many of these areas for mothers to seek the safety of hospital rather than gamble on the hazards of nature. This will frequently entail planned early admission in anticipation of labour, especially at those times when travel is most likely to become difficult. In many rural areas the rate for institutional delivery is now as high as 90 per cent.

99. Where home delivery is planned or where precipitate or premature labour makes the journey to hospital impossible or unwise, complications arise in a proportion of cases. This increases the responsibility and problems of the general-practitioner obstetrician. When conditions are bad a flying-squad may not be able to reach him for a relatively long time. He must be prepared to undertake procedures in these circumstances which he would not normally choose to undertake and his provisions for resuscitation must be the best he can provide. This implies constant preparedness for the rare emergency.

100. Because these happenings are rare and because he will not have the regular stimulus of working in hospital with its educational opportunities, which his urban colleague may enjoy, and also because he may not have enough obstetric work to maintain his skills, he must be able to attend regularly good refresher courses, which should provide adequate opportunities for practical work; the same applies to midwives in country districts.

101. If the isolated maternity unit has any place it is in areas such as this. Selection of cases must be as near perfect as possible to ensure that no case is admitted where complications could be anticipated, since last moment transfer greatly increases the hazards for mother and baby.

Flying squad

102. Domiciliary midwifery, the isolated maternity home and also the general-practitioner maternity hospital rely heavily on the provision of good emergency cover, because unforeseen complications can arise at any time and with frightening rapidity. It is vital, therefore, that every area should have a good flying-squad organization, and particularly the scattered rural area, which often suffers most from lack of support. There are some areas where, due to shortage of manpower, there is now no effective flying squad.

103. Provision of emergency services will be an even greater problem in future with a contracting domiciliary service and a possible reduction in the number of isolated maternity units. With less call on a flying squad it is more difficult but no less essential

that it is maintained in constant preparedness at a high level of efficiency: to achieve the best results the squad should be properly manned and equipped. The team should include an experienced obstetrician and an anaesthetist with experience of working outside hospital in makeshift conditions. A paediatrician should be available when required. In scattered and remote areas more sophisticated forms of transport such as helicopter or hovercraft should be provided for ambulance and flying-squad services.

VII

ADMINISTRATIVE PROBLEMS

104. The *tripartite administration* of maternity services, which came into being in 1948 has frequently been criticized as making for unnecessary difficulties. It can undoubtedly be a disruptive factor in this branch of the medical services, which has yet to achieve full harmony, but personal attitudes of doctors and nurses have contributed even more.

105. In recent years the local health authority has had a diminishing role in this service; with midwives being attached to doctors' group practices, their primary loyalty to another authority is becoming of less importance in the genesis of non-co-operative attitudes.

106. Assuming that, in future, something between 80 per cent and 90 per cent of mothers are to be delivered in hospitals or general-practitioner units, it would seem opportune to consider unified administration, but as the Cranbrook Committee suggested it is not realistic to consider such a major change for just one section of the medical services. Obstetrics would almost certainly benefit in the setting up of area health boards as recommended by the Porritt Committee or in some other co-ordinated administrative structure.

107. Maternity liaison committees must continue to be effective and active agencies to make closer the bond which in future must unite medical personnel working in this service. Their most important function will be to keep under active review the results in each area for both hospital and domiciliary deliveries to ensure that the highest possible standard is maintained at all times. They must

also ensure that adequate opportunities for continuing education are available for both doctors and nurses.

General-practitioner maternity units

108. There are many types of unit in which general practitioners deal with maternity cases, the range extending from a suite of delivery rooms with simple domestic furnishings attached to a specialist unit (Sluglett and Walker 1956, Duncan 1965) to a large unit where a great deal of abnormal obstetrics is undertaken (Young 1960). Some are open to all general-practitioner obstetricians in the district, some have a staff of general practitioners appointed by the hospital board; general practitioners have full clinical responsibility in some, others are under specialist supervision. The patients may come from the practices of the doctors responsible for their care, or some may come from the practices of other doctors.

109. The general-practitioner beds may be incorporated in a specialist unit, or they may be in a separate unit attached to, close to, or remote from the specialist unit. The majority of units to be planned will be in urban areas; in these circumstances the general-practitioner obstetric unit should be under the same roof as the specialist unit. This in turn should be part of a large general hospital.

110. No type of general-practitioner unit is ideal in all circumstances. It is desirable for a unit to be near to the specialist unit, so that specialist help will be readily available. It should be reasonably near to her home for the convenience of the mother and her family. Where it can be so sited, it should be under the same roof as the specialist unit, but where there is a centre of population remote from a specialist hospital and large enough to benefit from an isolated general-practitioner unit this should be provided. Wherever a unit is sited there should be close co-operation between the general practitioners and the specialist on whom he depends for support.

111. An experiment in integration at the Belvedere Hospital, Glasgow has been described by Stirling (1965) who showed how initial bad planning was overcome by good sense and co-operation between the various branches of the maternity service. Integrated units have been described at Kingston-on-Thames (O'Sullivan 1961), and Crawley (Reynolds 1961), others are at Hope Hospital, Salford (delivery rooms only), and Churchill Hospital, Oxford. The Area Department of Obstetrics in the Oxford Region contains a number of detached general-practitioner units. This area has a long and successful record of co-operation between specialist and general practitioner (Stallworthy 1952, 1961).

112. There have been other reports from general-practitioner units.

Jameson and Handfield-Jones, describing the situation at a Gloucestershire cottage hospital, warned of the danger of isolated units becoming too independent. Fitzgerald (1959) showed how a very low mortality rate was produced by strict case selection in two units near Manchester. Young (1960) and Stewart-Hess and Green (1962) reported units dealing with a great deal of abnormal obstetrics. Hobbs (1967) has reviewed the operation of general-practitioner maternity units in England and Wales. His analysis shows some of the advantages and highlights certain dangers.

113. The lesson learned from studying these reports is that closer integration must be the pattern for the future; it is in the best interest of mother and child.

114. Overall continuing and personal care is the special contribution of the general-practitioner obstetrician. When this can include delivery in hospital with its facilities and added safety then his patient will enjoy the best of both worlds. The unit is the place where all general-practitioner obstetricians in the area together with their specialist colleagues can review results both good and bad and take steps to improve the service. Such meetings have an important educational component not only for the general practitioner but also for his hospital colleagues.

Organization

115. The general practitioner should be at the hub of the obstetric service from which position he is ideally placed to co-ordinate other members of the team around him. He should be the link between services based in the community and those in the hospital. Ideally he should be one of a group of doctors supported by a full team including midwife, health visitor, home nurse, clerical staff and other ancillary workers with the assurance of consultant support whenever necessary. He should be relieved, when off duty, by another member of the group who can provide obstetric care of a high standard. Many doctors choose to be available for obstetrics even when otherwise off duty; midwives can be informed of a telephone number which enables them to contact the doctor even when his other calls are intercepted.

116. *Tracing patients who fail to attend* the antenatal clinic or for postnatal examination is a responsibility of a properly organized maternity service. This is easier for the doctor who practises in the domiciliary setting than for his colleague in hospital. It can be done in a variety of ways, but depends ultimately on an efficient appointments system.

117. When an obstetric patient is on the list of another doctor for general medical services, it is important that the latter should receive a report on conclusion of the case with details of outcome and

particulars of any abnormality or special features which may have arisen during pregnancy, labour or the puerperium.

118. *Equipment.* The general-practitioner obstetrician and the midwife with domiciliary commitments should be supplied with packs of sterile instruments and dressings from the hospital central sterile supply department. The doctor and probably also the midwife should carry oxygen and resuscitation equipment for both mother and baby. This should include intravenous fluid so that a drip can be started to replace fluids and combat shock where there has been excessive bleeding, until blood itself can be administered. In remote and scattered areas this type of provision must be as complete as possible. In all areas the ambulance service should carry resuscitation equipment and have facilities for transport of a premature baby with a nurse in attendance.

119. A lithotomy frame carried in the doctor's car is a valuable aid in domiciliary cases to facilitate suturing or forceps delivery. Radiotelephone communication is helpful in rural areas especially for keeping in touch with a patient in labour when other commitments must be met some miles away.

Records

120. The obstetric co-operation card introduced in recent years by the Ministry of Health is of considerable value where several persons or agencies are involved in the care of one patient. It has not been universally adopted however, and the general situation with maternity records is chaotic. Overlapping as described by Ellis (1968) is a common feature. In some places a patient has as many as four sets of records (all incomplete). There is an urgent need for a central body to formulate an obligatory obstetric record system for all branches of the National Health Service and suitable for working with computers for the purposes of analysis. This body must have lay experts well versed in record systems, work-analysis, work-study and computers.

VIII

FUTURE DEVELOPMENTS

121. The pattern of general practice as well as that of the maternity services, has changed rapidly in recent years. This evolution is gathering momentum and its trends must be studied to make a realistic appraisal of the future.

122. Our maternity services have been subject to constant examination and criticism over the years; this is as it should be with a new and evolving service, but even if British maternity services are not absolutely the best in the world, they are very good and improving all the time. Meticulous standards are needed to maintain results at the present high level. The accepted standards are, and need to be, very high; all who are engaged in this service must know and respect them. The evidence is that in recent years a higher percentage of young doctors coming into general practice has in fact attained the level of vocational training which the Royal College of Obstetricians and Gynaecologists and other authorities have said is desirable. In fact obstetrics has had a lead in this respect over other sectors of general medical practice.

123. In a number of advanced communities across the world (e.g. N. America, Scandinavia, Russia, Australia) it has been established practice over many years for nearly all mothers to have their babies in hospital. That this should be the pattern in Britain also has been strongly advocated by leading obstetricians and others (e.g. Claye 1955); that this has been delayed has been due in part to tradition, but even more so to economic strain and limited resources within the National Health Service.

124. In recent years an ever greater proportion of mothers is being admitted to hospital for delivery. This change has been facilitated by an increase in the number of obstetric beds, but even more so by a decrease in the average length of stay in hospital.

125. Theobald and his colleagues at Bradford were among the first to demonstrate that through enlightened co-operation between the three branches of our service a higher rate of hospital delivery could be achieved by a policy of planned early discharge without detriment to standards. They believed that the risk of complications would not be increased for mother or baby, and this has been borne out by later studies from Bradford recently published (Arthurton and Bamford 1967, Craig and Muirhead 1967). The disadvantages of early discharge and quick turnover have been enumerated many

times. We shall be constantly reminded of these by mothers, their families, and the organizations which represent their interests, unless we adopt effective measures to offset them. Our midwives too can suffer strain and frustration in this setting which we must alleviate as far as possible.

126. It would be unrealistic any longer to assume that the policy of early discharge is only a temporary expedient. The present trend towards more births in hospital is unlikely to be reversed, nor is it to be expected that a large number of new maternity beds can be provided to allow a return to a longer average stay. Maternity services cannot be considered in isolation; other specialties too have urgent need for priority in hospital accommodation, and all these services must come from taxation.

127. Planned early discharge can be perfectly satisfactory, providing there is effective consultation between all interested parties, and true co-operation is achieved. Among results to be expected when this spirit prevails is greater facility for the general-practitioner obstetrician to attend his mothers throughout, no matter where delivery takes place.

128. Home delivery should continue to be available for those mothers who desire it, who are suitable for it, and who have adequate homes. General practitioners and midwives responsible for domiciliary deliveries must, where possible, do sufficient obstetric work, including attendance on mothers from their district in obstetric units, to maintain efficiency.

129. Looking to the future there are many problems, not least among them being the evolution of general practice. In 1948 the majority of practitioners were single-handed and had little assistance. Now the majority are in partnerships; in urban areas they are tending to coalesce into larger groups with attached teams of ancillary workers, including midwives, health visitors, home nurses and secretaries. In rural areas co-operation with the nursing services has been a much earlier feature. As the team spirit grows the patient will have better service from members working in unison than when they worked in isolation and sometimes at cross purposes; with doctor and midwife in the same team maternity service will be more efficient. In large group practices it may be that a few members of the group will concentrate their interests in obstetrics, thus providing greater experience and expertise among a small number.

130. In education for general practice there have been rapid and profound developments in recent years, the full impact of which is not yet manifest. Plans for vocational training are well advanced and much has been done for continuing education. Some more

senior practitioners will have a new role in teaching which will tend to improve their own standards and efficiency; this in turn will be reflected in the attitude and accomplishment of younger practitioners. The quality of general practice in the future will benefit from this intellectual resurgence; general-practitioner obstetrics will benefit as much as any other sector of community medical care.

131. Discouragement and lack of co-operation in the obstetric service still confronts many young and enthusiastic doctors. There is ample evidence that in areas where co-operation is good and a friendly spirit prevails the best and most satisfying service can be provided. It is only when such a spirit is to be found throughout Great Britain that the full potential of this service will be realized. We hope that day is fast approaching.

SUMMARY

The history of the family doctor's role in the field of obstetrics has been traced up to the present day. The maternity services of the National Health Service have been reviewed. Likely trends and possible developments in the future have been considered. The general-practitioner obstetrician has a decisive part to play in this service. The best ways of achieving this in the changed circumstances envisaged have been discussed. Future development depends on integration and co-operation based on mutual confidence between specialist and general-practitioner teams.

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