HOME DELIVERIES

Sir,

I would like to support what Professor Huygens (April *Journal*) has said on the safety of well-selected domiciliary confinements, both from my own experience in England, and from what I have learned during the three years I have lived in Holland.

I get the impression that in England now one is repeating that " hospital is a safe place to be born " far too readily, and without considering the statement too critically. There do not seem to be many reports on the immediate availability throughout the 24 hours of really senior obstetric skill in the hospitals; or how this may depend on area; or how it may vary between individual hospitals in an area. The outcome of labour depends partly on the level of anticipatory awareness throughout the conduct of the labour, and this depends on the experience of the obstetrician or midwife, whether outside or inside hospital, as well as on technical facilities.

My impression of district midwifery here and in England is that everyone is very much aware that one can not afford to tolerate the beginning of a potentially serious situation which can be easily avoided by simple means; whereas in hospital one may have the availability of skilled surgical attention as the ultimate resort always at the back of one's mind, influencing one's conduct of a case. Perhaps therefore more fully developed situations requiring " aggressive " treatment do arise in hospital.

From my own experience of domiciliary deliveries in England in a semi-rural practice handling nearly 300 home confinements in six years, in only one instance did we have to call for emergency assistance on the district. The equipment and a senior obstetrician arrived in 30 minutes—which compared favourably with my experience as a senior house officer in a North London hospital, when on occasions senior obstetric assistance had to be obtained from central London.

I personally have never had to admit a case during labour from home to hospital, and our experience of home confinements was by no means as fraught with difficulties and emergencies as some recent reports would indicate.

I can confirm Professor Huygens' view that in Holland giving birth is regarded as a very ordinary event. A woman is expected to be as efficient in producing her baby as in washing her windows and performing her other housewifely tasks. It is not attended by a build-up of mystery, anxiety, and boiling water; and English doctors here are convinced that the patient does accept pain more readily, not only in childbirth, than we do in England.

A. J. MARY CHISHAM

Bartolottilaan 36,
Soest,
The Netherlands.

REFERENCE

Huygen, F. J. (1976). *Journal of the Royal College of General Practitioners*, **26**, 244–248.

UGANDA FACULTY

Sir,

It is sad to be reminded that the flourishing Uganda Faculty was forced to disband in 1971 as a result of their government's racial policy. But governments and policies change, often with surprising rapidity on the continent of Africa, and the College will again be represented by a faculty there.

Dr E. R. Gibbons' action in sending us the lion skin will be appreciated by us all, but I hope that he agrees with me that the description you gave of it being a " lasting memorial to the Uganda Faculty " is too final. Should we not reassure Dr Gibbons that, when the time comes, the College will hasten to support him and his colleagues to reform the Faculty?

M. J. AYLETT

Pickwick House,
Pickwick,
Corsham,
Wilts.

REFERENCE

Journal of the Royal College of General Practitioners (1976). **26**, 353.

JARGON

Sir,

Presumably Dr Maycock's letter (May *Journal*) was his response to Brook and Temperley's paper (February *Journal*). As one of the general practitioners involved in this multi-disciplinary project, I sense his resentment at the condescension connected (in some undisclosed way) with social workers appearing good at the expense of the general practitioners. As put by Dr Maycock it seems a very real conflict, not " contrived " at all—and that is why it was so valuable to work with other disciplines, to share cases and examine the professional implications of this sharing, by which we were able to study the difficulties and expectations of each profession, and think about consultation and responsibility without " betraying the principles of their respective disciplines ". Indeed learning a " robust sensitivity " *was* our business.

The Royal College of General Practitioners has championed the heresy that there are many patterns of care in our cases, depending on our assessment of pathology and the anxieties aroused by this in the patient, as well as in ourselves and others. We looked at cases in which *several* people were suffering discomfort or pain, some clearly named as patient, some disguised (relative, or maybe doctor or social worker) and Dr Maycock must have as much of this problem of suffering as any of us, and must know that doctors are very quick (as they need to be sometimes, but not always) to identify the patient (for example,

giving him too many medicines): and the Tavistock Clinic is well-known to make anyone feel like a patient on walking through its doors!

Dr Maycock's aggressive dismissal only underlines his concern for his own role, his own robustness, sensitivity, and professional detachment, and the need for settings with other disciplines in which we can face the real problems of collaboration. We face, for example, the envy of those without open-ended contracts, on whom impossible and unthought-out demands may be put; of those who may well envy us our power and being so needed; and even those, perhaps, who envy us the insights and support we received in this project.

Could we now have Dr Maycock's and others' comments on Graham and Sher's paper?

C. W. L. SMITH

Group Practice,
1 Jackson's Lane,
Highgate,
London, N6 5SR.

REFERENCES

Brook, A. & Temperley, J. (1976). *Journal of the Royal College of General Practitioners*, **26**, 86–94.

Maycock, C. (1976). *Journal of the Royal College of General Practitioners*, **26**, 358.

OUT-OF-HOURS WORK

Sir,

With reference to your correspondence (April *Journal*), on out-of-hours work, Dr Barley may be interested to know that a Cooperative Deputising Service was approved by the Leeds Local Medical Committee in 1968 and would have provided a service to more than 500,000 patients and 200 doctors as did, and still does, the existing commercial service.

It was felt that a service whose first consideration was adequate manning would be preferable to one whose prime motive was profit.

Despite the fact that considerable initial finance was subscribed by would-be participants, the service was never launched because of the very doubts that Dr Barley expresses about continued co-operation, which might have led to undesirable competition for suitable spare medical manpower to keep it operational.

I doubt if human nature has changed much since 1968 and must regretfully consider that syndicalism is a non-starter in this field of human activity and the choice is between commercial or departmental monopoly.

I agree with Dr J. C. B. Thomson about the educational value of the concentrated experience to be obtained by working for a deputising service and hope a way will be found of getting all those involved interested, and all those interested involved, be they trainers, trainees, organisers or operators. Every one involved, even patients, would benefit.

M. DALES

355 Harrogate Road,
Leeds, 17. Yorks.

REFERENCE

Barley, N. H. (1976). *Journal of the Royal College of General Practitioners*, **26**, 257–258.

Thompson, J. C. B. (1976). *Journal of the Royal College of General Practitioners*, **26**, 257.

PSYCHOTHERAPY IN GENERAL PRACTICE

Sir,

It must be a risky business for someone with a specialist background to address his generalist colleagues in your columns, since he is vulnerable to the charge of trying to teach grandmothers to suck eggs. Dr R. A. Johnson (April *Journal*) does not entirely succeed in avoiding this pitfall. He writes, " I am confident that many general practitioners already use their personality as a major factor in the management of their patients." His confidence is well-founded. A quarter of a century's research by Balint and his co-workers, and a bibliography from general practice, attest to this. Yet your correspondent contrives a fairly long letter on this subject without mentioning Balint once: a notable feat in itself.

Not that Balint said the last word on the subject. But he said the first words that made any sense to us, and he achieved this, like Dr Johnson, by eschewing jargon; and also, unlike Dr Johnson, by disclaiming even " the simplest possible theoretical structure ". In other words, he knew he didn't know, and the new look in general practice was founded, literally on a new looking.

I find that trainees in particular are receptive to this approach, with its absence of cant and peddling of theories. Balint dropped the term " psychotherapy ". His work was really about how we observed patients, how we understood them as people, and how we made ourselves available to them; in short, what was involved in being a proper doctor.

J. S. NORELL
Dean of Studies

The Royal College of General Practitioners,
14 Princes Gate,
London, SW7 1PU.

REFERENCE

Johnson, R. A. (1976). *Journal of the Royal College of General Practitioners*, **26**, 261–262.

DIVERS IN THE NORTH SEA

Sir,

In a recent letter in the *British Medical Journal*, Dr J. W. Taylor of Dyce, Aberdeen, who I presume is in general practice, draws attention to his observations on divers working in the oil fields in the North Sea. He expresses the wish that doctors working in those areas should exchange their medical observations on divers, who represent a new group of patients working below water, using pressurised air for respiration.

Since this is a field where general practitioners are primarily involved, I suggest that the College