LETTERS TO THE EDITOR

GENERAL-PRACTITIONER OBSTETRICS

Sir,

We report the outcome of admissions to the City of Gloucester general-practitioner maternity unit during the last ten years (Table 1).

Our annual perinatal mortality rate for the years 1967 to 1976 inclusive has thus varied from a minimum of nil to a maximum of 10·13 with an average of 4·37 over the whole period.

Our results have been more fully reported in the *South-West England Faculty Newsletter.*

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Reference

South-West England Faculty Newsletter (1977). April.

Table 1. Outcome of admissions to the City of Gloucester maternity unit from 1967 to 1976.

	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
Total cases	99	795	963	983	1,086	847	803	757	755	697
Delivered in gp unit	83	685	809	819	861	751	600	566	559	543
Transferred to consultant unit	16	110	154	164	225	196	203	194	196	154
Perinatal deaths	0	0	1	8	11	5	1	4	3	1
Perinatal mortality rate	0	0	1.04	8.14	10.13	5.90	1.25	5.28	3.97	1.43
Home deliveries	448	310	109	69	41	23	12	7	7	1
Total cases in the five other general-practitioner units	—	—	—	1,511	1,566	1,470	1,277	1,216	—	—
Total cases in consultant unit	2,236	2,258	2,325	2,184	2,376	2,202	2,226	2,191	2,058	2,029

COURT COMMITTEE

Sir,

At a recent meeting in Wessex, a group of general practitioners considered the recommendations of the Court Report as they applied to general practice. They presented the following comments and we would like, as fellows of the College, to associate ourselves unequivocally with them:

1. We were unanimous in that we deplored the emotional gut reaction of the profession, perhaps without the full knowledge of the facts, certainly without reading the full Report, and probably without reading the summary. We deplored the dramatic report in the popular medical press on the deliberations of the General Medical Services Committee and the Royal College of General Practitioners, and we consider that these august bodies are somewhat out of touch with the profession and have some doubt as to their recent experiences in developmental paediatrics. You can criticize someone without shooting him.

2. We agreed unequivocally that the curative, preventive, and surveillance services should be merged in the interest of the child and the family. It makes clinical and economic sense and is the best way to use scarce resources.

3. We considered it a pity that the label 'general-practitioner paediatrician' was invented and in this our member of the Court Committee agreed. We thought that he should be called a "general practitioner with a special interest in paediatrics". Group practice has been developing in recent years with many members having a special interest and skill in paediatrics. We consider that 30 per cent of our workload is, at the moment, taken up with children. The 70 per cent figure mentioned in the Report is a bone of contention and should have been left open and negotiable. At the moment 50 per cent of general practitioners are doing sessional work, 50 per cent are doing their own developmental paediatrics, and 75 per cent state that they would be interested in more paediatric involvement. We consider that all general practitioners should be involved in paediatric care, but at present training is inadequate. The school medical service has routine work that might well be taken over by general practitioners. Education and advice is a more difficult matter and should perhaps be dealt with by one who has a special interest and training. The problem is more simple in rural than in urban areas.

4. We think the present primary health care team should include, as well as nurses and health visitors, a psychologist and a nominated social worker, with a special interest in children. Where a general practitioner does not wish to take special responsibility, or does not have the experience to do so or thinks he has not the experience to do so, then a clinical medical officer could move in. This is not the level of the community paediatrician. We appreciate that this is in the experimental stage; we must see which development is best.

Furthermore, we deplore the failure of the College Council, in preparing its response to the Court Report, to consult the growing number of members around the country who have done much original research into the kind of primary care surveillance which Court recommends and whose known views have been studiously neglected.

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Cowes, IW.
PAUL HOOPER
Newport, IW.
GORDON STARTE
Guildford, Surrey.
JOHN TURNER
Leytonstone, Essex.

Reference

Committee on Child Health Services (1976). Court Committee Report. Cmnd 6684. *Fit for the Future.* London: HMSO.

PRACTICE ORGANIZATION COMMITTEE

Sir,

The College has re-formed the Practice Organization Committee of Council, and this Committee is now keen to study the wide variety of organizational ideas prevalent in general practice today. It is aware of the wide variations in the range and sophistication of practice organization methods in regard to premises, equipment, and routines. One of the things which is apparent is that many such features, which were introduced in some practices years ago, have still not been adopted in others, and there are new ways of doing things coming into use all the time. Even today, however, there are many practices whose principals have not introduced any such features of practice organization, and seem to have relatively little job satisfaction. They may or may not realize that they have little chance of recruiting high quality vocationally-trained junior partners, because they are not aware of what can be done in practice to make their work more efficient and more effective, and therefore more rewarding.

The Practice Organization Committee is therefore trying, first, to identify such new ideas, and secondly, to help spread those which seem to be generally useful. Eventually the Committee will play its part in formally evaluating new methods of practice organization, but the development of the methodology for this is difficult. Meanwhile, it is proposed to collect information and publish a *Gazetteer* of practice organization on a national and regional basis. Thus, enquirers can go and see in action the practice features which they are interested in. In order to do this the Committee is asking all the faculties, regional advisers in general practice, and departments of general practice to identify such practices to the Committee. Similarly, we are asking general practitioners who visit the Practice Organization Room in college headquarters at 14 Princes Gate, or who make enquiries of the POC Secretary or the new General Practice Information Service, to inform the College of any features in their practice which could be adopted by other practices with advantage.

It is hoped that the *Gazetteer,* once it has been compiled, will be circulated to faculties, and it may perhaps be possible to circulate it to postgraduate centres so that enquiring doctors can quickly find out what is new in their area and visit practices with special features. We therefore ask all readers of the *Journal* who are interested in practice organization, whether in respect of premises, equipment, or routines, to write to our Secretary, Dr K. J. Bolden, at the address below. We will then be pleased to discuss ideas individually with each respondent.

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JOURNAL STYLE

Sir,

May I point out that your literary standards fell from their usual high level in the book review section of the April issue? I hope that those of us who play, "guessing the author", when reading editorials will not now start to, more maliciously, "guess the sub-editor".

On page 252 we must swallow (where the use of liquorice is described) the use of commas before "ands" if only because Fowler explains why we should do so, but successive 'ands' in the same sentence cannot claim a similar respectability. On the same page,I am sure that the International Study implies some *comparisons* of standards rather than *matching* of them. In the following review, I am worried by the geometric concepts involved where "cross infection can occur in infancy and upwards". Finally in the last paragraph on this page, your reviewer "describes an argument". I suspect that this is a correct use of the verb but it is a quaint one.

I do not want to carp or nit-pick for the sake of it but such a cluster as this warrants comment.

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COMMUNITY MENTAL HEALTH SERVICES

Sir,

The Government White paper *Better Services for the Mentally Ill* (1975) emphasizes, in the paragraph on general policy for the future (chap. 2, para. 17), the basic idea of community-orientated care, although so far it has been unsuccessful in practice. "In the future the main aim must be the development of more locally based services and a shift in the balance between hospital and primary care", *using our present resources.*

I recently visited Canada and saw the Red Deer psychiatric service at Alberta, which is financed by the provincial government over an area of 2,600 square miles. The mental health services are based on a community psychiatric nurse working with the support of a visiting psychiatric social worker and specialist psychiatrist. Referrals are accepted from individuals, families, clergy and schools, and anyone seeking help may decide whether or not to have his or her problem discussed by the team.

I also visited Regina, Saskatchewan, were there were three district teams served by two psychiatrists, a social worker and two community nurses. Family practitioners there worked mostly independently of the government services and referred their patients to private psychiatrists.

In Ontario I saw the Kitchener Waterloo Hospital and the Crisis Intervention Centre, formed in 1970. This clinic is staffed by six psychiatric nurses, a full-time social worker and a part-time clinical psychologist. It operates as a unit within the outpatient department of psychiatry under the administrative direction of a psychiatrist, who assumes ultimate medical responsibility. The cost was about $100,000 a year in 1972.

It seems that many patients would attend the Crisis Centre rather than pay either directly or indirectly via the Ontario Health Insurance Plan, to see a general practitioner. The lack of continuing care of patients by general practitioners may have contributed to the apparent success of the centre.

I could not find any comparative study evaluating the effectiveness of such a centre with hospital admission rates.

I concluded that team work does not evolve automatically just because professionals are attached together.

Shared accommodation in health centres is likely to improve the understanding of other professionals' work, but practice meetings are unlikely to be productive if the necessary skills in group-work are lacking.

We need to accept that to care for our patients we must care for each other and our caring for each other is a reflection of our capacity to care for ourselves.

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Reference

Department of Health and Social Security (1975). *Better Services for the Mentally Ill.* London: HMSO.

JOINT SENSE

Sir,

Joint sense is a very sensitive mechanism for determining muscular action. Does it ever fail? I recently thought it might help to explain the sudden and complete collapse of the healthy young athlete who, with full mental vigour and concentration, is confronted with a knee cartilage lesion with which the reticular proprioceptor centre cannot cope. This may be the cardinal factor in the disc lesion of the knee and also the lumbar spine—the joints especially needed in fight and flight and, therefore, the joints of major significance in the reticular proprioceptor centre.

In such cases, one sees momentary shock, then the restless swivelling anxious eyes, the gradual recognition of his hopeless situation by progressive trial movements, which indicate that the whole proprioceptor system is called into question. If this is so, why should the stress factor have an adverse effect similar to that seen in the behaviour system? The man with the arthritic knee is 'surprised' when his knee lets him down because the reticular formation has already been informed of the knee defect but the healthy athletic individual