AFTER DELIVERY CARE

Sir,

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

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

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

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

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

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

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

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

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

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TRAINING IN OCCUPATIONAL MEDICINE FOR GENERAL PRACTITIONERS

Sir,

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

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

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

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

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

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

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

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HOME VISITING IN A NORTH-EASTERN MINING COMMUNITY

Sir,

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

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

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

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

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

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References

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Table 1.

Year	Number of patients	Number of visits	Visit per address	Visit per patient	Number of night visits	Rate per 1,000 patients
1969	3,300	3,974	1.20		70	21.21
1970	3,240	3,422	1.06		45	13.89
1971	3,210	3,061	0.95		35	10.90
1972	3,170	3,378	1.06		53	16.72
1973	3,145	3,277	1.04		59	18.76
1974	3,120	3,088	0.99		76	24.36
1975	3,095	3,325	1.07		75	24.23
1976	3,055	3,177	1.04		70	22.91
1977	3,030	3,319	1.09		92	30.36
1978	3,010	3,344	1.11		81	26.91
Average for 10 years	3,137	3,336	1.06	1.28	65.6	20.91

The figures for 1977 have been marginally corrected since first published (MacRae, 1978)

Table 2.

Year	Number of patients	Surgery appointments	Appointment per patient on list	Appointment per patient corrected from sample
1972	3,170	10,698	3.37	3.86
1977	3,030	10,224	3.37	3.86
1978	3,010	11,210	3.72	4.26

*A sample during two weeks in 1977 and 1978 showed that a second patient was seen or treated at every seventh surgery consultation.

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WHAT KIND OF COLLEGE?

Sir,

Of 1,100 doctors recently invited to an evening meeting in Oxford to discuss the future of the Thames Valley Faculty of the College, only about 50 attended. Of those who did turn up it was the view of at least one founder member that before thinking too much about its future the College should think a bit more about the present and the past. It should ask itself why after 25 years fewer than one third of the doctors eligible to become members or associates are in fact members or associates, why of those who are members or associates only very few take any interest in the activities of the College, and why more than 95 per cent of the doctors invited to such an important meeting did not attend.

The answers to these questions seem to me to be straightforward. The average general practitioner is busy all day earning his living. In the evenings and at weekends he likes to be at home. If he leaves his practice during the day he leaves extra work for his partners; if he leaves his home in the evenings and at weekends he leaves his family and his hobbies. Most doctors are not prepared to do either of these things and so just do not go to meetings.

But, you may say, a few doctors *do* give up their evenings, do find ways to take days off from work, do elect to have a small list and a small income. Just so—and how odd that they do, thinks the silent, non-attending majority. Does this oddness, it goes on to muse, perhaps account for some of the oddnesses of the College itself—that vast and expensive building, those bizarre fund-raising activities, the endless stream of blue-covered journals and reports, so long on vogue words and so short on interest, the truly awful approach to something called 'education', the very notion that one doctor should set out, like a ring master his sea lions, to train another? Yes, odder and odder the more you think about it, reflect the stay-at-homes.

What then should the College do? It should reform its ostentatious ways and concentrate all its efforts on making it possible for a doctor to reduce his list size without diminishing his income, for until general practitioners have less work and more time the College will have as active members only those odd fellows who prefer role play to home life and those few others who feel for some reason a need to polish up the image they have of themselves as general practitioners.

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ANGLO-AUSTRALIAN EXCHANGE

Sir,

How I envy the astonishing amount of spare time that Drs Rhodes and Marsh seemed to have at their disposal in Chagford (May *Journal,* p.302)! Assuming that they work a five-day week, they are seeing 13 patients in their surgery and visiting just over three patients a day—a truly enviable state of affairs. One wonders what the Australian doctors made of it, particularly as their own consultation rate of 140 patients per week could hardly be described as sweated labour!

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