Is obstetrics optional?

"MOST general practitioners think of midwifery as a subject peculiarly their own" wrote Taylor in 1954. Today we publish papers on obstetrics which give us an opportunity to ask why that statement should now seem such an anachronism.

The first is the monumental analysis by Wood of his 25 years as a general practitioner obstetrician—precisely the person described by Taylor, delivering half of his patients in their own homes, another third in a general practitioner maternity unit and referring only a fifth to consultant care in hospitals. He has shown clearly that in the right hands home delivery can be safe, even for the 42 per cent of women who are high-risk cases. The perinatal mortality in his 818 mothers was 10.9 per thousand, achieved, as he points out, "without any of the new obstetric and paediatric technology," and in a rural area where conditions were often less than ideal. Marsh (1977) has previously published a series almost as large as Wood's, with even better results: delivering 71 per cent of his patients under the care of himself and his primary care team, he achieved a perinatal mortality rate of only 8.5 per thousand. Marsh attributed the higher proportion of normal deliveries in his series to the influence of "continuing and personal care by a long-known doctor" and to the reluctance of the general practitioner working in a normal unit to "over-react with . . . interventions to minor abnormalities or . . . delays." Finally, it is worth recalling the 10 years' experience of the general practitioner unit in Oxford (Bull, 1980), where 60 per cent of 8,000 mothers were delivered entirely under the care of their general practitioner and midwife, and with a perinatal mortality of only 12.2 per thousand of all those originally booked for the unit.

It is in Bull's paper that we begin to see the trend which concerned the College's Working Party on Obstetrics, whose discussion document is on page 72. Bull points out that the average number of patients booked per practice fell to only 25 per year by 1977, with only three practices in Oxford admitting more than 40 patients per year in their own care. The Working Party, in their figures from six family practitioner committee areas, show that 1,129 doctors made an average of only 9.1 claims each in 1979 for delivering their own patients. They also show that in the city of Newcastle-upon-Tyne only 11 per cent of general practitioners were undertaking confinements at all.

Falling birthrate, rising interference

Nobody can be good at something he seldom does, especially if we are talking about a process as potentially complicated and dangerous as delivering a woman of a normal healthy baby. "Lack of experience" and "loss of confidence" are never going to appear as categories in a table of statistics, but might these two factors be important reasons why many general practitioners have stopped delivering babies?

To set alongside the changing experience and skills of the general practitioner there is also the changing—and to some patients the unacceptable—face of modern obstetrics. The 1973 to 1976 *Hospital Inpatient Enquiry* (based on a 10 per cent sample of all maternity patients in hospitals in England and Wales) shows some very large changes indeed: 83 per cent of women were discharged from consultant units, 37 per cent of all deliveries were induced (this figure was 49 per cent in 1974), over half of all women had an episiotomy and one in eight was delivered by forceps. The slowly rising rate of caesarean section (7.1 per cent in 1976) is noted in the HIPE Report and also analysed in more detail by Francome and his colleagues (1980). They point out that the UK figure in 1963 was just over three per cent, and that in the USA it has now climbed to over 12 per cent; Francome *et al.* note that in one hospital in Long Island, New York, the rate was 25.7 per cent of all patients.

This last astonishing figure represents interference at its extreme. The case for it has strong (but perhaps false) medico-legal connotations: some doctors seem to feel that it is better to risk disaster by doing something (for instance caesarean section) than to risk it by doing nothing. The pressure to do something will also increase as technology supplies us with the means for the doing —drugs, drips, pumps, monitors and the surgeon's scalpel are all equally difficult to leave unused in the cupboard.

It is hardly surprising, therefore, that lack of practice and a steady distancing from the techniques of the specialist unit should combine to make the general practitioner obstetrician feel that his hold on normal midwifery is increasingly tenuous. It is also likely that as more and more general practitioners use deputizing services, fewer of them will want to be constantly on 24-hour call for their pregnant patients.

The future of general practitioner obstetrics

The Working Party make nine recommendations. The first is that the profession should decide whether ante-

natal and postnatal care is an essential or optional component of general practice. If it is essential, then well-directed training for it is also essential. Furthermore, such training is different from that needed for the practice of intranatal care. Another important recommendation is that arrangements for obstetric training and continuing education should be transferred to the Regional Postgraduate Medical Committees, and that clinical audit (exemplified by Dr Wood's paper) is both appropriate and feasible.

The question that all general practitioners and obstetricians must ask themselves is "What do our patients want and what do they need?" Are maternity welfare groups like the National Childbirth Trust "fuddy-duddy middle-class mothers" as Mrs Renée Short MP is said to have described them (1980), or are they right in objecting to Mrs Short's House of Commons' Committee which, inter alia, recommended that all births should take place in hospital, and that it should be mandatory that all women should be seen at least twice in their pregnancy by a consultant obstetrician? The College is discussing the whole question of obstetric care with the Royal College of Obstetricians and Gynaecologists; evidence, tempered by moderate doses of opinion, is needed to guide our negotiators, and readers are invited to send it to the Honorary Secretary of Council, whose letter appears on page 121.

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Everybody's business, nobody's responsibility?

THE phrase 'prevention is better than cure' turned into a colourless cliché so long ago that most of us have ceased even to think whether it might still be true; we have tended to throw it onto what George Orwell called that "huge dump of worn out metaphors which have lost all evocative power . . .." There is plenty of evocative power, however, in the three documents on preventive medicine which we publish today. Health and Prevention in Primary Care (No. 18), Prevention of Arterial Disease in General Practice (No. 19) and Prevention of Psychiatric Disorders in General Practice (No. 20) are first fruits of the Working Party on Prevention set up by the College in 1978. They help us to answer two big questions: does prevention work? and can general practice do it? The reports also suggest certain specific tasks for general practice in the fields of arterial disease and psychiatric illness.

Does prevention work?

This question directly tests the cliché, and it is perhaps inevitable that more answers are to be found in the report on arterial disease than in the one on psychiatric disorders. Several of the risk factors for arterial disease —cigarette smoking, raised arterial pressure and blood fats, obesity and physical inactivity—can indeed be altered, and there is evidence, some direct, some more circumstantial, that altering them will prevent or delay the appearance of stroke, myocardial infarction, sudden death, peripheral arterial disease, heart failure and renal and retinal damage. Probably about one half of all strokes and one quarter of all coronary deaths under the age of 70 are preventable.

The position is less clear with psychiatric disorders because their causes are so much less clearly definable. In Report number 20, however, the Working Party subcommittee present persuasive evidence that life events, or psychosocial transitions as they call them, produce psychological reactions and disorders for which the general practitioner is frequently consulted. The committee give many examples both from childhood (for instance separation from parents, home and school) and from adult life (marital breakdown, pregnancy, loss of job, or retirement), of times when the effects of severe stress can be partially relieved by good primary care. Anticipatory guidance has been shown to reduce the risks associated with major surgery, childbirth and release from prison; supportive intervention has been effective in improving long-term adjustment after bereavement. "It seems reasonable to assume," the committee go on, "that anticipatory guidance will be equally effective in preparing people for other types of predictable changes in their lives."

Can general practice do it?

Most doctors are probably already doing more prevention than they realize: it would be a very unusual day in the life of most general practitioners if there were no consultations for antenatal or postnatal care, family planning, cervical cytology or the immunization of children. Many primary care teams are also doing some