PATIENTS' ACTIVITIES

Health in the round—Voluntary action and antenatal services

The National Council for Voluntary Organizations is to publish its report on antenatal services and voluntary action in May 1983. Mr Andrew Purkis of the Policy Analysis Unit of the NCVO, and one of the authors of the book, has sent us this account of an exciting new publication.

LAY parents themselves know more about the nonmedical aspects of having children than anyone else. And becoming a parent is a massive life-change, much of which has little to do with medicine. Yet the knowledge, enthusiasm, experience and skills of 'ordinary' people are largely shut out of today's antenatal services. The common absence of effective partnership with the voluntary sector is a fundamental mistake if we want to meet the diverse requirements of parents-to-be.

Nobody has a more important role in enabling ordinary people to help Britain's future parents than the general practitioner and the primary health care team. But how?

Support for Voluntary Action

Much attention has been paid since the Short Report to questions of improving the quantity and quality of professional resources for the antenatal services, to the coordination of effort between different professionals and to the style which professionals adopt in their individual encounters with future mothers. The relative roles of obstetric consultants, general practitioners, midwives and health visitors has been another favourite subject.

The National Council for Voluntary Organizations has now mounted an initiative to open up another vital yet missing dimension of the debate: cannot some of the most important needs of future parents best be met by others in the community? And should not health authorities and professionals enable and support different kinds of voluntary action as an integral part of developing antenatal services?

What we have done, thanks to the financial support of the DHSS and one of the Sainsbury Family Trusts, is to bring together and analyse in one volume a wide cross-section of pioneering initiatives up and down the country. Our report, *Health in the Round**, shows what voluntary organizations and volunteers are already doing to promote many different aspects of antenatal health and suggests a great potential for the future. It identifies seven key growth areas with concrete examples and contacts to follow up:

Voluntary action in clinics and classes

Current examples of good practice include running creches, chaperoning, translating for ethnic minorities and providing information on breastfeeding and welfare rights.

Primary health care teams can play a key role in mobilizing lay people for such purposes at the neighbourhood level—one good reason why more antenatal care for low-risk mothers should be delivered locally rather than be centralized in hospital clinics.

Helping the NHS to reach high-risk mothers

Ethnic minorities, single parents, teenage mothers, the very poor, the homeless: those in greatest need are those least likely to use current NHS services. Voluntary organizations and volunteer schemes can help—by personal communication, encouragement and support or by practical assistance with transport or baby-sitting.

Successful voluntary schemes work in styles and settings that do not deter those who may shy away from uniforms and authority figures. They often mobilize the influence of people's peers to help them on terms that they can accept.

Choosing between NHS services

Voluntary bodies at national and local levels can make women more fully aware of the options available to them—for example by producing directories, by home visiting schemes or by advising individual mothers who are meeting resistance to their wishes.

Influencing NHS services

Apart from their familiar campaigning role and their representative function on health authorities and community health councils, voluntary organizations have found important ways of developing consumer opinion and influencing services through forming working groups with health service staff. These can review services generally, or review particular issues or plan individual projects. The experience of patient participation groups is one of various relevant models.

Preparation for parenthood

The work of the National Childbirth Trust is justly famous, but its principles and objectives have yet to be translated into terms relevant either to the mass of working class women or to those with special needs.

Individual NCT teachers, and a number of other organizations, are mounting exciting experiments in helping many more ordinary mothers and fathers to help others prepare for parenthood in many different social and cultural contexts. This is sometimes a matter of new styles, settings and methods for group work, centred on the particular needs and wishes of the parents concerned, and sometimes of individual home visiting and befriending. All this is especially important for the 50 per cent or so of mothers who currently give NHS classes a miss.

Promoting healthier pregnancies

Few doctors will doubt the importance of general fitness and healthy habits before and during pregnancy, including the time before the antenatal services come into play in a mother's life at all. Voluntary organizations can be particularly relevant, because through them mothers can choose to take more responsibility for their own health and can think out what they need in order to live more healthily.

The growth of women's health, natural health and community health groups of various kinds has been striking.

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Many other voluntary organizations work with women of childbearing age and can incorporate a significant health dimension—given the necessary encouragement and help, not least from their local primary health care teams.

Specialized advice and support.
Voluntary organizations provide much specialized advice on subjects like breastfeeding and maternity rights. Equally significant is their support to 'special needs' groups such as single women, ethnic minorities, prospective mothers of twins or those facing complications in their pregnancies. Such support is often based on mutual aid and the use of lay peers and, like a great deal of voluntary action, endures far beyond birth itself.

To talk about voluntary projects in such general terms always does them a disservice—they sound abstract, and fall prey to the reader's prejudices about the character and value of voluntary action. The detailed facts of what is actually being done speak loudest, and our report is punctuated with case studies, information sheets and practical information. Busy professionals can use it to see how particular needs can be tackled without necessarily reading more than the summaries of the accompanying arguments.

Need for Professional Backing

And this *is* very much a matter for health professionals themselves. Of course there is much more that various voluntary organizations and community health councils can do. But virtually all the pioneering initiatives under consideration rely to a greater or lesser extent on professional backing. They need reliable, statutory funding. They need access to NHS facilities. They need support and expertise from NHS staff.

This presents a major challenge to those working in the NHS who are accustomed to dealing exclusively with individual patients. Even if they are aware that voluntary action and volunteers do not grow on trees, they can assume that their development must be somebody else's business. Our argument is that meeting the health needs of future parents in the round should involve the health services at all levels in an active commitment to partnership with groups of lay people—in enabling voluntary action as well as treating individual patients.

Nor is this a utopian idea. Practical initiatives under way testify to the practicability and promise of partnership with the voluntary sector. Individual general practitioners are to the fore in beginning to develop voluntary action in the seven growth areas identified above. We hope this report will be a helpful starting-point and guide for many others.

CONTROVERSY

Why time the MRCGP examination at the end of vocational training?

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Surveys of attitudes to the MRCGP examination amongst trainees have all shown similar reasons for sitting it (Griffiths, 1981; Taylor, 1982; Bond, 1982). The most common reasons are to help get a job, and a fear that the examination may become more important in ways that are not foreseeable at present, but of which becoming a trainer is an obvious example. Self-assessment, pride and a stimulus to study are also common reasons, but very few (3 per cent in Devon and Cornwall) stated the reason that they wanted to become members of the College.

THESE feelings were again expressed at the Sixth National Trainees' Conference in 1982, at which there was overwhelming support for an alternative to the examination—possibly along the lines of "What Sort of Doctor?". There seems to be general discontent amongst trainees with the present arrangements.

The Peterborough scheme, amongst others, proposes that admission to the examination be postponed until about two years after completing vocational training. However, Dr John Hasler, speaking at the Sixth National Trainees' Conference on behalf of the College, stated that the College saw a need to provide an endpoint assessment to vocational training "for those who want it"—only 21 per cent in Devon and Cornwall—or as stated in the Conference Report, "if that is what is demanded" (Bradley, 1982). I have a nagging feeling of unrest about this difference of attitude.

A good doctor?

What makes a good doctor is that indefinable element called spirituality to which Prince Charles alluded in his Presidential message to the *British Medical Journal* on the BMA's 150th anniversary. Since it cannot be dissected nor boiled in a test tube, we have no teaching on spirituality. My own understanding of it has grown because I am a Christian doctor and because my belief that Man is body, soul and spirit with a conscious mind, not just body and mind, affects my medical practice. Our entire medical training and hospital service is body orientated, with only a passing reference to pathology of the mind. The whole concept of mind that we thus develop is inadequate for the practice of medicine outside hospitals, where problems of the soul or spirit may be of prime importance.

The trainee year in general practice provides inestimable potential for making a transition from body and biochemistry orientated medicine to whole person medicine under the supervision of an experienced practitioner. This transition requires personal growth, not only emotionally but spiritually, to produce a shift from understanding diseases to understanding people. Such growth proceeds by diversification and experimentation hand in hand with the application of knowledge: and the product is known as sound clinical judgement.