outpatient hospital care. It seems that the clinics were acceptable to patients, general practitioners and hospital doctors alike.

In the discussion the following points came up:

1. That mini-clinics or some other form of general practitioner based care was acceptable and beneficial for sufferers of a variety of chronic illnesses.
2. That the use of such clinics in various chronic diseases would probably increase in the near future.

It seems to me that many general practitioners, including myself, will be interested in promoting these clinics in one form or another in our surgeries and certainly that the hospitals will be encouraging us to do so. An important point is that these clinics will cost money to set up and to run. A major part of this cost will be manpower, since although workload in our general surgeries may be slightly reduced, it is likely to lead to an overall rise in our workload. Indeed, one doctor pointed out that if all the partners in a practice were doing specialist mini-clinics on a certain day, there would be nobody left to do the general surgeries. The consequence of this may well be that partnerships will wish to take on extra doctors, which, with scarcity of jobs, is no bad thing.

Where is the money to come from to pay for the extra staff required? It seems that the National Health Service's determination to move clinics into community care is not matched by any willingness to provide funds to do so. The Health Minister's intentions can be deduced from his reply in the House of Commons to Labour MP David Nellist when he asked about provision of item of service payments: 'We expect general practitioners to provide a wide range of services to their patients but do not expect to provide a special item of service fee for every item.' It would seem, therefore, that no extra money (for item of service and other payments) will easily be made available for primary care.

I predict that unless this matter is monitored most carefully general practitioners will find themselves providing extra care free of charge (except to their own pockets) and I would strongly urge all doctors to be aware of this possible development. I would emphasize that we would not be asking for money to improve our standard of living, but merely to provide the best possible care to patients in a new sphere. I am, therefore, echoing Dr R.B.H. Maxwell's concern as expressed in his letter (July *Journal,* p.414).

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General practitioner obstetrics — a visitor's viewpoint

Sir,

From January to June last year I enjoyed a practice exchange with a general practitioner from Oxford, England. This exchange arose out of our meeting in 1979, firstly in New Zealand, and later in England. We had a mutual interest in general practitioner obstetrics and are both concerned that general practitioners should continue to participate in the management of their patients during both pregnancy and delivery. Having worked in England for six months, I now volunteer the following thoughts on the matter.

Articles in the medical press recently have warned that participation by general practitioners in intrapartum care is likely to disappear completely in the near future. The changes leading to this situation appear complex and often paradoxical. The emphasis in general practitioner obstetrics for many years has been to eliminate risk factors. Home deliveries have been actively discouraged as dangerous, and all-enveloping specialist units have been developed. Small general practitioner units in rural districts have been closed ostensibly on account of financial economies, and patients have been referred to the base hospital. General practitioners have been encouraged to continue to provide antenatal and postnatal care, otherwise the present system would be unworkable, since travelling too often to attend regular hospital clinics would be extremely unpopular with patients, and the clinics would be overcrowded. The result of these trends is that, whereas in New Zealand general practitioners are still responsible for more than 50 per cent of all deliveries, in the UK this figure is now below 15 per cent.

The community midwife, for many years the key figure in domiciliary obstetrics, has had her position eroded by the removal of deliveries from the home to the hospital. In response she may now discourage the general practitioner from intervening in his own cases until a problem occurs and transfer to a specialist becomes inevitable.

The first paradox is that if the general practitioner obstetrician disappears it seems likely that the community midwife will follow suit. Both need to work in a spirit of co-operation to retain their practices, but a general practitioner who never makes decisions in obstetrics and who does not use modern technology as well as more traditional obstetric skills, will soon lose interest.

A second paradox is to train a majority of general practitioners to the level of obtaining the diploma in obstetrics and then to discourage him or her from practising because of lack of patients, or opportunity to look after them. It is perfectly understandable that not all general practitioners will be interested in this aspect of family medicine, but surely in every group of four or five there should be at least two prepared to accept this particular responsibility. I believe that since at least 50 per cent of obstetric cases are 'low risk' these should be delivered in general practitioner care, to the advantage of both patient and doctor.

The third paradox is to see general practitioners withdrawing from obstetrics at a time when recent advances in this specialty have made the process of parturition far less uncertain and stressful to patients or doctors than at any time in the past. The use of ultrasound scans, prostaglandins, intravenous oxytoxics, fetal monitors and epidural analgesia have all contributed to this change, and should no longer be unfamiliar to the properly trained general practitioner. These techniques have made the management of obstetrics much safer and less traumatic for all and the days of long drawn out labours with consequent maternal, fetal and obstetrician distress have almost disappeared.

In discussing the possibility of general practitioner obstetricians disappearing, it should be stressed that ready consultation and co-operation with our specialist colleagues is essential. Early referral or consultation is not an admission of failure, but usually results in a feeling of increased confidence by patients, midwives and doctors. A final paradox will arise if general practitioner units are closed due to apathy or indirect pressures. If all patients are to be delivered in base hospitals, there will almost certainly be a significant upsurge in the demand for home deliveries. General practitioners should endeavour to avoid this happening or they will face dissatisfied patients whose demands they will be unable or unwilling to meet.

Many excellent general practitioner units are already established in the UK and working happily in conjunction with

specialist units. The unit at the John Radcliffe Hospital in Oxford, where I have worked, is a model for standards of excellence and regular detailed auditing of results. Where such facilities are available, general practitioners should endeavour to use them to their full capacity. Where they do not yet exist, there should be continued pressure to give general practitioner obstetricians the opportunity to look after their appropriate patients. A concerted effort by all concerned will be needed to prevent the irreversible loss of true general practitioner obstetricians.

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Practice nurses

Sir,

The General Practitioner District Committee in north-east Essex recently sent out a questionnaire to all practices in the district in order to discover the range and extent of services provided by practice nurses. The opening of a new district general hospital is anticipated to increase the workload of the community nursing staff and the Committee wished to know whether practice nurses would be able to increase their role in the care of patients following discharge from hospital.

Twenty of the 44 practices in north-east Essex employ nurses, 70 per cent of the total population are served by practices which employ practice nurses. The majority of nurses employed are part-time. All 20 practices have a nurse present on the practice premises during morning surgery and three practices have a nurse on duty throughout the working day from 08.00 to 20.00 hours. Duties performed by the nurses are shown in Table 1.

Table 1. Duties of practice nurses

	Number (%) of practices
Changing dressings	20 (*100*)
Removal of sutures	20 (*100*)
Assisting with minor operations	19 (*95*)
Assisting with antenatal clinics	19 (*95*)
Diagnostic procedures	17 (*85*)
Immunization procedures	17 (*85*)
Phlebotomy	16 (*80*)
Family planning advice	11 (*55*)

The survey demonstrates the significant contribution made by practice nurses to the health care of the community. Seventeen of the 20 practices indicated that they were prepared to take on extra nursing workload. Only two of the practices employ nurses who are fully qualified to work in the patient's home and there was a lack of enthusiasm for extending the role of the practice nurse in this way.

Looking to the future, it is important that hospital staff need to be made aware of the existence of practice nurses and refer ambulant patients requiring dressings appropriately.

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Source of hospital admissions in Wakefield

Sir,

We have always been under the impression that most patients were admitted to hospital at the instigation of their general practitioner, apart from those few who suffer sudden illness or injury outside their own home.

The experiences of one of us (A.G.C.) in the hospital posts of vocational training questioned this assumption and prompted us to attempt to measure the source of admissions to the general medical and paediatric beds in Wakefield over a period of six weeks.

Our results are summarized in Table 1. General practitioners formally instigated only 41 per cent of 274 successive admissions to the general medical and paediatric departments. They contributed, in some way, to the admission of a further 13.4 per cent (37 patients) via outpatient attendance or domiciliary visits by a consultant. Professional deputies admitted a further seven patients (2.5 per cent of all admissions). Forty per cent of all patients were admitted directly from the accident and emergency department. All but one of these patients were self-referred. One patient was referred to the accident and emergency department by the general practitioner for radiological assessment of fractured ribs and surgical emphysema; she was admitted. Other sources of admission to both departments were transfers from other departments and hospitals.

Of the 81 patients admitted to the paediatric wards, 46.9 per cent came directly from the accident and emergency department. The general practitioner contributed, directly or indirectly, to only 46.8 per cent of admissions.

Of 113 patients admitted directly from the general practitioner to the general medical or paediatric wards, only 81 (72 per cent) took with them a referral letter. There was some doubt in five other cases.

The clinical indications for admission from the accident and emergency department were intriguing. So far as adults were concerned, 31 of the 72 patients admitted in this way were suffering from self-poisoning. A further 19 of the 72 were suffering from chest pain — 15 of these were found to have significant cardiac pathology. Syncopal attacks of various types, haematemesis and dyspnoea were other common causes of admission. So far as children were concerned, the most common cause of admission directly from accident and emergency was minor head injury. Convulsions, either first or subsequent, accounted for a further eight. 'Others' included such diverse conditions as vomiting, Henoch-Schoenlein purpura, hypoglycaemia, septicaemia and upper respiratory tract infection.

We find it sad that general practitioners contribute nothing to nearly half the emergency admissions of their patients. Emergency admission to hospital is, after all, a major event. It is understandable that patients suffering major trauma or sudden, apparently severe, illness outside their own home may, with