

General practitioner obstetrics

FOR many years general practitioner obstetrics has had to defend its position as a viable alternative to specialist care. All over the Western world an increasing proportion of confinements are taking place under specialist care, even in countries like the Netherlands, which has special traditions of home delivery. Underlying this trend is the question of quality. Do specialists look after patients better than general practitioners?

In recent years evidence has accumulated which suggests that, given the essential preconditions of enthusiastic and interested general practitioners — a well-equipped general practitioner obstetric unit, a supportive specialist service and rigorous selection of appropriate patients — the results of general practitioner obstetrics in general practitioner units when judged by the conventional yardstick of perinatal mortality are as good if not better than those in specialist care.

This leaves the further question of whether the feelings and impressions of the women themselves favour delivery in a general practitioner or a specialist unit.

Professor Michael Klein, from the Department of Family Medicine, McGill University, Canada, and Ms Diana Elbourne from the National Perinatal Epidemiology Unit, Radcliffe Infirmary, Oxford, have taken advantage of the situation in Oxfordshire where natural geographical factors make it possible to conduct a comparative trial of bookings for delivery. Two groups of women were studied — those who were delivered in a specialist unit and those who were delivered in a general practitioner unit.

The evidence suggests that the groups of patients were comparable and indeed the design of the study virtually ensured this. It appeared that those women who were delivered in the general practitioner unit were more frequently visited by general practitioners and throughout their period of antenatal care made contact with a smaller number of midwives and doctors and were less likely to receive conflicting advice. These women were more likely to be seen at home by a midwife before coming into the general practitioner unit, were admitted a little later in labour, and therefore spent less time in the unit and subsequently had fewer obstetric interventions of various kinds.

Some of the differences which were significant, such as the women having their babies with them in hospital all the time, appear to relate to patterns of organization in a particular unit rather than any inherent feature of specialist or general practitioner care, whereas some of the other findings may well be inherent advantages of the general practitioner system.

At the point of delivery, general practitioners were present for 38 per cent of cases in the general practitioner unit and one per cent of cases in the specialist unit; consultants were present for two per cent of deliveries in the specialist unit and none of the deliveries in the general practitioner unit.

It must, of course, be emphasized that all the women in this group had been carefully selected for entry to the study by excluding all indications both for consultant care and home delivery. They would therefore generally be regarded as a low-risk group, as indeed they proved to be.

The overall conclusion of the study is that the differences identified were relatively small and that both systems of care were generally very satisfactory to the mothers. This study therefore supports and justifies the claims of the protagonists of general practitioner obstetric care.

Professor Klein and his colleagues can be congratulated on producing a useful contribution to this important subject, which remains worthy of further study in the future.

Booking for maternity care — a comparison of two systems, Occasional paper 31 can be obtained from the Publications Sales Office, Royal College of General Practitioners, 8 Queen Street, Edinburgh EH2 1JE, price £3.50 including postage. Payment should be made with order.

Cardiopulmonary resuscitation: a survey of junior hospital doctors

The theoretical knowledge of cardiopulmonary resuscitation of 50 junior hospital doctors was examined, and an attempt made to assess their practical ability to manage a collapsed patient. Major defects were found in both the doctors' theoretical knowledge and their practical abilities. Only 8 per cent were able to manage a cardiopulmonary arrest adequately.

In the practical test, none of the 50 doctors would have fulfilled Safar's rigorous criteria for effective basic cardiopulmonary resuscitation. Four doctors (8 per cent) did adopt a logical approach to resuscitation and were able to ventilate the mannequin and perform cardiac massage in an effective manner. Their overall performance was considered to be satisfactory. Twenty-five doctors (50 per cent) were unable to maintain a patent airway and ventilate the mannequin, and 37 (72 per cent) were considered unable to perform effective cardiac massage. Most performed it far too slowly and only compressed the sternum 30–40 times in the two-minute test period. Safar considers that 60 compressions should be performed in the first 100 seconds. Several doctors, most of them female, also failed to compress the sternum far enough and so would be unlikely to produce an adequate cardiac output.

Suggestions are made as to how standards might be improved.

Source: Casey WM. Cardiopulmonary resuscitation: a survey of standards among junior hospital doctors. *J R Soc Med* 1984; 77: 921-924.

Risk of death after myocardial infarction

Psychosocial interviews with 2,320 male survivors of acute myocardial infarction, participants in the β -Blocker Heart Attack Trial, permitted the definition of two variables strongly associated with an increased three-year mortality risk. With other important prognostic factors controlled for, the patients classified as being socially isolated and having a high degree of life stress had more than four times the risk of death of the men with low levels of both stress and isolation. An inverse association of education with mortality in this population reflected the gradient of the prevalence of the defined psychosocial characteristics. High levels of stress and social isolation were most prevalent among the least-educated men and least prevalent among the best-educated. The increase in risk associated with stress and social isolation applied both to total deaths and to sudden cardiac deaths and was noted among men with both high and low levels of ventricular ectopy during hospitalization for the acute infarction.

Source: Ruberman W, Weinblatt E, Goldberg JD, et al. Psychosocial influences on mortality after myocardial infarction. *N Engl J Med* 1984; 311: 552-559.