## Maternity care: *not* a duplication of resources

Sir,

Sarah Robinson is right to lament the medical take-over of the midwife's role (July *Journal,* p.346). However she is wrong in equating more general practitioner involvement in the full care of women with a duplication of skills.

Enlightened general practitioner obstetricians wish to return a more active role to midwives, and we have the power to do so. The sooner those of us who recognize the importance of this (consumers, midwives, doctors) work together as allies, rather than perpetuate age-old battles, the better.

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## Standards in training and non-training practices

Sir,

Dr Baker's comparison of standards in training and non-training practices (July *Journal,* p.330) was usefully thought-provoking.

I was interested in his inclusion of appointment systems. Although I note that he was careful not to say that their maximal use characterizes the best practices, the implication is apparent: 'Training practices employed more staff, were more likely to operate a full appointment system, and undertook preventive health screening more often. They were generally better equipped, performed more educational activities and were more likely to agree to participate in local audit schemes ...'

In the same issue of the *Journal,* Sir George Godber in his William Pickles Lecture (p.320), rightly urges us to be ready to change and to evolve according to local requirements with particular sensitivity to our practice population: 'a continuous process of change and development produces an acceptable result. Someone's revelation of the ideal structure imposed from the centre does not.'

Thus, not long ago we abandoned our full appointment system for a small part of the week (as described in The *RCGP Members Reference Book* 1982, p.236) and find from our patients that the service we now provide which includes a completely unbooked session on market days, is considered a better one.

Those who in the 'typical training practice' (Dr Baker's phrase, not mine) make comparisons of standards, would do well to remember the enormous variety of types of practice, many of which have become finely tuned over the years to the specific needs of their communities. Comparers can only too easily become arbiters.

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## Sampling of chorionic villi

Sir,

In an otherwise excellent editorial on sampling of the chorionic villi (July *Journal,* p.316), Peter Stott totally missed the point with respect to the introduction of this new technique and Down's syndrome.

The real issue in Down's syndrome detection is that the vast majority of these babies are now born to younger mothers and that this decreasing maternal age is a world-wide phenomenon. As this point was heavily borne out in a paper published in this *Journal,*[1] I would have expected the writer to have at least mentioned the point. Furthermore, a recent study, alas published elsewhere[2] has suggested that risk of Down's syndrome is related more to maternal morbidity and drug prescribing than to maternal age as such.

In our protocols of detection we now have a 'Maginot line' where the outdated 'over 35' rule requires to be reinforced by a more precise definition of risk. It is in this respect that chorionic villi sampling and ultrasound hold out the hope of a more targeted detection programme. With that in mind Dr Stott does not even mention the most important factor involved which is the cost of the technique relative to amniocentesis.

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**References**

1. Murdoch JC. A survey of Down's syndrome under the care of the general practitioner in Scotland. *J R Coll Gen Pract* 1982; **32:** 410-418.
2. Murdoch JC, Ogston SA. Characteristics of parents of Down's children and control children with respect to factors present before conception. *J Ment Defic Res* 1984; **28:** 177-187.

## Frequent attenders in general practice

Sir,

I found the paper by Dr Westhead on frequent attenders (July *Journal,* p.337) to be comprehensive, interesting and informative. I am sure that it goes some way to answering the question many of us wearily ask from time to time: 'Why, whenever there is an outbreak of diarrhoea or an influenza epidemic, do the same damn patients seem to get it every time?'

Dr Westhead makes the important point that this group of frequent attenders is worth looking at because of its effect on the workload of the practice, and I agree with him. But let us not forget the effect of other interreacting factors, such as the attitudes and behaviour of the doctor. What we do and how we do it has a profound effect on the way our patients behave, on their consultation rate, and therefore on our workload.

Maybe we should ask some questions of ourselves when confronted by the notes of frequent attenders. With the group suffering from long-term physical problems we could ask how frequently we need to monitor a well-controlled hypertensive. Could we delegate this to a practice nurse, and if we did would the standard of care be affected? Which patients are we helping by merely nodding and smiling and telling them to carry on taking the tablets for their arthritic limbs? Is this being supportive, or is it repetitive benign neglect while our brain is on automatic pilot? What proportion of these surgery attendances are doctor-initiated as opposed to being patient-initiated? If we have asked the patient back to see us again, are we quite clear why? Do our crowded waiting-rooms reflect our popularity or our ineffectiveness?

With regard to the 'psychoneurotic' group attending a practice partnership of three or more general practitioners, we should not only look at the frequency of attendance — we should also look to see if practically every entry is written by a different member of the practice where the patient has 'done the rounds' with related symptoms. Is his 'doctor promiscuity' a further sign that he cannot form and maintain relationships with anyone — let alone his doctor? How far is this behaviour encouraged by the doctor, either unconsciously by failing to recognize the real reason for attending, or consciously by passing him to another partner to sort out? Recently one new patient, when asked who her last doctor was, told me: 'I didn't have one — we were in a group practice.'