difference is not found when these two groups are compared in years 5–8, which would cast doubt on age being the underlying reason only (unless we postulate that the Harris women are ageing faster!).

4. This point is also answered in the text of our article (see Observations). The study was initiated a year after the factory closed and the data extracted from our practice records during the period July 1983 until September 1984 and by just one of the four doctors in the practice, thus the possibility of observer bias can apply only to one of the eight study years and then only for a quarter of the patients (those consulting N.R.B.). In other words 31/32 of the data is free of any such bias.

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Sir,
We are a group of doctors who are meeting as part of the MSD Scottish Leadership Course. As one of our joint tasks we agreed to review the November 1985 issue of the *Journal.*

Using a rating scale to evaluate the articles for interest, relevance, quality and readability a high degree of accord was reached for the article 'Job-loss and family morbidity' by Beale and Nethercott. It was agreed that the study was of high quality, of interest to us, and relevant to general practice. In addition it seemed from reading the editorial 'Job-loss and the use of medical services' that there is a paucity of relevant information regarding unemployment and health.

If this is really the case then it would seem that general practitioners are the ideal group to establish the facts and we would be interested to know if others think likewise? This does seem an important issue and a widespread problem, and raises the question of whether this is an area of work to which the Council of the College should be addressing itself.

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Personal lists

Sir,
Dr Tant's editorial (November *Journal,* pp.507-508) contains many untested assertions that would be open to complete rebuttal. In addition the conclusions he draws from his own unfounded premises are suspect.

In his first paragraph he implies that if partners are committed to dealing with all the work that is generated from their own personal lists then the distribution will be equal. How is this achieved? Even if the list numbers are kept more or less level, it is likely that individual doctors will attract patients of a particular kind that may involve more or less time. For example, one partner may be more interested and skilled in obstetrics and find that he has the largest share of maternity work in the practice. It is not uncommon for the oldest partner to have the greatest proportion of elderly patients in the practice who require more medical attention and home visiting. In some practices one partner may have more experience and interest in psychiatry and he is likely to collect patients who take longer to treat than those with obviously organic conditions.

Dr Tant says that the system he supports can only work if none of the partners is away from the practice for more than one session a week in addition to his half day. At whose expense can this be achieved? Certainly there is no obligation on us to do clinical assistantships or industrial medicine, but who is to serve on the NHS committees or run the postgraduate education programmes?

Two or three years ago those attending a trainee seminar were asked to bring three records from their practices. Some came from practices with separate lists and others from those with combined lists. On looking at the last 10 consultations in the records, on average only seven consultations had been with one doctor no matter what kind of practice the patient attended.

The concept of separate lists appears to exist chiefly in the mind of the doctor but is important, for if the patient believes himself to be a patient of a particular doctor but nevertheless is obliged to see another doctor for three out of 10 consultations he will be more put out and critical than if he knew that the practice ran a combined list. Indeed, I wonder whether it is the doctor who needs to feel that he has his own patient rather than the patient who wishes to have his own doctor.

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Sir,
Dr Tant's editorial on personal lists provides a summary of many of the main advantages of this system and we feel that it has great relevance to quality of care in general practice. However, in examining one of the most fundamental principles of practice management we do think it is important to review the issue critically and to examine carefully the disadvantages of this system as well. Historically the debate was opened by Forman[1] in 1971 and Marsh and Kaim-Caudle[2] contributed considerably in the mid-1970s, as did Aylett[3] in 1976.

This subject was reviewed in detail in 1979[4] in the North of England Faculty lecture 'The key to personal care' and the term personal lists was introduced to emphasize the importance of the personal relationship between a patient and a doctor compared with the previous term 'separate lists'. Analyses from our practice in the same article showed changes associated with the adoption of a personal list system in 1973.

We are enthusiasts for this system and we do believe that it offers the potential for better patient care. However, we take seriously some of the difficulties, including for example the problem of patients wishing to consult a particular partner who undertakes developmental child care or women patients wishing to see a woman doctor for gynaecological conditions. Freeman[5] reviewed this subject recently.

It is not yet scientifically certain that 'patients undoubtedly prefer having a personal doctor'. We believe that they do, but proper academic evidence on a controlled basis is not yet available. Nor is it true that 'the system breaks down if a partner is involved in other medical activities and spends several sessions away from the practice'. All three of us take more time out from the practice than one half day a week but still find the personal list system satisfactory. It does mean, however, that adjustments have to be made in such practices, for example to the list sizes.

We would be glad to hear from other practices which have changed their policy towards personal lists and to learn of the opinions of the partners and staff after this change has taken place.

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Place of birth and perinatal mortality

Sir,
Marjorie Tew has demonstrated that the received wisdom of active management of labour in hospital does not stand up to close scrutiny (August *Journal,* pp. 390-394).

While statistics are clearly essential, no discussion of the niceties of statistical analysis hides the arrogance, bigotry and prejudice of those doctors who continue to refuse to recognize the significance of the iatrogenic problems resulting from high-technology hospital confinement, the advantages of active birth both in hospital and at home, and the right of women to choose the place where they give birth.

A woman's right to an informed choice of place of birth is a fundamental part of the philosophy of those of us who see doctoring in terms of promoting health, self-determination and responsibility, and of sharing our power and knowledge. Properly supervised home birth for suitable women is as safe or safer than hospital confinement. Home birth, low-technology care, active rather than passive birth, all represent a positive attitude to health which we should be supporting.

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Sir,
The issue of home versus hospital birth continues to be overshadowed by the anxiety threshold of the attendants, thus diverting attention away from the harsh arithmetical reality which has been so expertly dissected by Marjorie Tew not only in this paper (August *Journal,* pp. 390-394) but elsewhere.[1-3]

The real significance of the paper has so far escaped attention. It is a fundamental premise of the concept of a booking policy that all patients other than those in the low-risk category should be referred for specialist care in order to ensure a more favourable outcome than would otherwise have been the case if they had not been transferred. Assuming this new data from the *British births 1970* survey does not conceal a hidden selection bias then this premise has been shown to be without foundation. In fact it appears that the reverse is true, which means that the higher the risk category in which the patient falls, either as a result of her past obstetric history or events during pregnancy and the first stage of labour, the less likely it is that she will lose her baby if looked after by her general practitioner.

Some health authorities have sought to curtail the clinical freedom of general practitioners by issuing them with a contract which makes the use of general practitioner unit beds conditional upon close adherence to the booking policy. It may have escaped the attention of these health authorities that no-one has so far felt the need to provide any evidence that this is in the best interests of patients. The booking policies vary considerably themselves, not only from district to district but in the same district over a period of time (Leece G, Chairman, District Maternity Services Committee, Hastings Health Authority, personal communication).

Madley and Symonds (November *Journal,* pp. 536-537) say that they suspect that the clinical acumen or gut feeling of general practitioners, midwives and obstetricians is the cause of a hidden selection bias and that this has been underestimated by Mrs Tew. If Mrs Tew underestimates this factor, have not administrators and their advisers also underestimated this capability among those general practitioners who would rather exercise this faculty than be saddled with an enforcible, inelastic booking policy which has now been so clearly shown to be ineffectual in achieving the purpose for which it was designed?

May I suggest, therefore, that in the next two years during the implementation phase of the Korner Committee recommendations on data collection in the maternity services, serious consideration is given to replacing the booking policy with a statistical profile for each general practitioner and consultant obstetrician which can be generated as an extension of the 'minimum data set' concept and which would allow both peer review and self-auditing to occur concurrently. This would be a much more finely tuned instrument for both encouraging a favourable outcome and monitoring and discouraging the reverse.

Madley and Symonds make the comment 'the data on which her [Mrs Tew's] case is based are almost ancient history'. Since the 1958 and 1970 surveys are unique and have not been repeated either in this country or any other it is not surprising that the existing interpretations of their findings have had a profound effect on the development of maternity services in this country. It is all the more regrettable that Fedrick's[4] conclusions which must have contributed to the process of dismantling the community intra-natal midwifery service have not been retracted in view of her failure to draw similar conclusions from the 1970 data, when looking at the same selected patients as in the 1958 survey.[5]

Furthermore, some searching questions now need to be asked as to why it was that Volume 2 of the *British births 1970* survey results first appeared a full eight years after they were collected. When unpublished data which would have thrown further light on place of delivery statistics were identified in 1979 by Marjorie Tew it was a further six years before these data were released by the custodians (to whom it had been entrusted by the National Birthday Trust) and published in the *Journal.* Perhaps the Korner Committee data collection system will also shorten what has been a 15-year planning–research cycle.

It must surely be of serious concern to both administrators and planners in this field that because of the successful implementation of the booking policy in most parts of the country, with the result that general practitioners are only looking after low or very low risk mothers, it is now difficult if not impractical to reinvestigate its scientific validity even though the installation of the necessary information technology will make this a relatively easy task. An exact parallel can be drawn with the widespread implementation of ultrasound screening on normal mothers before full evaluation, which now presents the Medical Research Council with the difficult, if not insuperable, task of attempting to exclude possible small risks such as dyslexia.[6] It is of some concern that the Royal College of Obstetricians and Gynaecologists have overlooked this possible danger in their report[7] and have recommended that the practice of routine ultrasound examination at 16–18 weeks gestation should continue.

The World Health Organization has now lent its full weight to the USA consensus statement, *Diagnostic ultrasound imaging in pregnancy* published by the National Institute of Health in 1984.[8] This makes the specific observation that 'data on clinical efficacy and safety do not allow a recommendation for routine screening at this time'. The World Health Organization also made the general point that thorough evaluation of health technologies should precede their widespread use. Mrs Tew has made a valuable contribution to the evaluation of health care policies by the only means available to a statistician but unfortunately it may now be too late.

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