THE PLACE OF THE GENERAL PRACTITIONER IN THE OBSTETRIC SERVICES

JOHN T. CORBETT, M.B., CH.B., LL.B., M.R.C.S., L.R.C.P.
Wellingborough

The lack of general-practitioner obstetric beds is probably the greatest single factor leading to the decline in the amount of obstetrics dealt with by general practitioners. Therefore it may be of interest to review the work done by a practitioner in an area where a general-practitioner unit exists, with a view, particularly, to observe the distribution of cases between specialist and general-practitioner care. This may give some idea of the part an interested family doctor could expect to play in the midwifery services if the necessary facilities were provided for him.

The local general-practitioner unit is modern, excellently run and consists of 25 beds. It is situated in what was orginally entirely a hospital for chronic sick together with Part III accommodation for the aged. There is a pathological laboratory on the premises, staffed by qualified technicians and visited regularly by a pathologist. There is a minimum of blood stored for an emergency transfusion. The relations between local general practitioners and consultants is excellent, and a consultant opinion may be easily obtained with minimum of delay. All family doctors on the obstetric list who reside within 5 miles of the unit may attend their own cases there, and each week two are on call for sudden emergencies should the patient's own doctor not be available or not desire to be on the list of those attending the unit. Normal cases only are booked on "social grounds". This term is very wide and the local authority health visitors and midwives assess the relative need for a bed, though multiparae with four or more children are allotted a bed as a matter of course, and are persuaded to accept a bed often against their own desire.

When he first sees a patient the family doctor must decide whether the patient should be confined in a consultant unit, whether confinement can be safely undertaken at home, or whether application

should be made for a general-practitioner obstetric bed on "social grounds". There are two consultant units, one 10 miles and one 7 miles from the general-practitioner unit, and naturally the patient's own doctor will send to them women who are the subject of obstetric or other clinical abnormalities of significance.

When a maternity patient is booked for confinement in the specialist units the consultant obstetrician is, of course, responsible for the antenatal care, but he may in many cases, at his discretion, refer the patient back to her own family doctor for some of the routine antenatal consultations. This obviates many long wearying journeys and long periods of waiting in the outpatient department. It is very important in these circumstances that there should be efficient exchange of information between all those dealing with the case.

When the case is booked for home confinement or confinement in the general-practitioner unit the patient may attend either her own doctor or the local health authority antenatal clinic for her antenatal care, though the majority of general practitioners will prefer to do this work themselves, and a doctor sufficiently interested will find that most of his patients will prefer to attend him. In any case the women should attend local authority clinics for health education and relaxation classes, a most important part of the local authority service. There will, of course, be a proportion of cases where, though originally normal, abnormalities will develop during pregnancy necessitating a transfer of the booking to a specialist unit, and others where sudden emergencies occur during labour. In the latter cases, it may be more expedient to bring specialist help to the patient rather than to transfer her to the specialist hospital.

There is a growing awareness that antenatal consultations should be separated from the work of ordinary surgery sessions, and as a result many general practitioners hold special antenatal clinics of their own, often finding it convenient to combine these with infant welfare work, particularly as a young pregnant mother may have to bring along with her a previous infant. The record cards should be separately filed and some kind of calendar of appointments devised so that it is at once obvious if a patient defaults from attending when expected. In the latter cases, which in my experience are very few indeed, either doctor or local midwife must take the necessary steps to follow up the patient. Co-operation and the interchange of information between doctor and midwife is essential, and antenatal notes must be available to the midwives in the general-practitioner unit when a patient is admitted in labour. The women are encouraged to call at the unit to meet the staff and to see the wards sometime during the pregnancy. The sister-in-charge wel-

comes this on one afternoon each week.

Between 1 Jan. 1955 and 30 June 1960 there were 236 confinements and 17 miscarriages in my practice, a total of 253 pregnancies.

The numbers of pregnancies according to parity were:

Primigravida		101	Para	V	6
Para	I	71		VI	8
	II	33		VII	3
	III	15		VIII	2
	IV	13		IX	1

Of these 253 pregnancies, 17 ended in a miscarriage, with the exception of two cases at the 8th week abortion occurring between the 12th and15th weeks.

The parity of those women in whom miscarriage occurred was as follows:

Primigravida		2	Para	III	1
Para	I	7		IV	2
	II	4		VIII	1

It is interesting to note that serious haemorrhage occurred in two cases only, in each case where miscarriage occurred at the 8th week. Blood transfusion was necessary in both.

Of the remaining 236 pregnancies, a booking was requested in a specialist unit in 36 cases, and there were 200 bookings for confinement at home or in the general practitioner unit. Of these latter 200 cases, confinement was necessary in a specialist unit in a further 32 cases, either because abnormalities arose during pregnancy or because of emergencies during labour. Each of these groups will be analysed.

Cases Originally Booked for Confinement in the Specialist Units

According to parity the reasons for requesting a booking in a specialist unit were as follows:

Primigravida	Elderly primigravida	1
(18 cases)	Already attending hospital, ? missed abortion	2
	Already attending hospital for treatment of sterility	2
	Booked on " social grounds "	6
	Booked at expressed desire of patient	4
	Already attending hospital for severe epilepsy	1
	Mitral stenosis	1
	Hyperthyroidism	1
Para I	Previous premature stillbirth	2
(11 cases)	Previous stillbirth at term	1
	Previous stillbirth and retained placenta	1
	Previous retained placenta	1
	Toxaemia of pregnancy	1
	Hypertension and previous toxaemia of pregnancy	1
	Previous child died of congenital atelectasis	1
	Woman aged 49 years, first child 24 years old	1

	Expressed desire of patient	1
	Severe psychological disturbance? for termination	1
Para II	Rhesus negative, antibodies present	1
(3 cases)	Hypertension and previous toxaemia of pregnancy	1
	Expressed desire of patient	1
III	Booked on " social grounds " and toxaemia	
(1 case)	of pregnancy	1
VI	Threatened abortion and recent nephrectomy	1
(3 cases)	Booked on " social grounds "	1
	Recent sanatorium treatment for tuberculosis of kidney	1

Cases were booked on " social grounds " because there was no bed available in the general-practitioner unit, and those who expressed desire to be confined in the specialist unit had been nurses trained at the hospital in question.

Toxaemia of pregnancy. In this group there were five cases of pre-eclamptic toxaemia and one case of hypertension necessitating admission to hospital during the antenatal period. The case of hypertension had previously had a premature stillbirth, and three cases of pre-eclamptic toxaemia occurred in those patients booked for the specialist unit on " social grounds " or because of the patients expressed desire.

Abnormal presentation. There was only one, an extended breech.

Forceps deliveries numbered six, for foetal distress in two, and prolonged second stage in four.

Caesarean section was performed on a para I for a transverse lie and foetal distress, the patient having previously had a stillbirth. This child subsequently proved to have congenital pulmonary stenosis and an intra-ventricular septal defect.

There was one *premature labour.* The mother, a para I had had a premature stillbirth at her first confinement. The infant weighed 3 lb. 10 oz., and had a convulsion on the third day. Subsequently further fits occurred, there was some degree of mental retardation, strabismus, and a minor degree of retrolental fibroplasia.

Cases in which Confinement took place at Home or in the General-Practitioner Obstetric Unit

There were 168 in all, the numbers according to parity being:

Primigravida	58	Para	V	6
Para I	49		VI	4
II	25		VII	1
III	12		VIII	1
IV	11		IX	1

There were few antenatal complications in this group.

(1) Two women developed infective hepatitis necessitating admis-

sion to hospital—one a primigravida, and the other a para II—the former at 14 weeks and the latter at 9 weeks.

(2) One woman, a para I had copious vomiting for 7 days at 33 weeks. She was admitted to the specialist unit and vomiting settled on conservative treatment. No satisfactory explanation was found for this vomiting which resembled that in chronic pyloric stenosis.

(3) Repeat blood counts were carried out at about 30 weeks, and in six cases haemoglobin had fallen to between 60 per cent and 70 per cent, although previous investigations had been satisfactory and all patients had received supplies of iron, usually tab. ferromyn. Intramuscular injections of imferon were given to four patients, one case was found to be a macrocytic anaemia and responded to iron and folic acid, and the remaining patient responded to colliron.

(4) Hyperemesis gravidarum warranted admission to hospital of one patient and settled satisfactorily.

(6) A general-practitioner obstetric unit is not intended for the treatment of hypertension or pre-eclamptic toxaemia, but in fact five mild cases were admitted for rest, sedation, to obtain a better assessment, to do laboratory investigations, and also obtain a second opinion. These cases settled well. Careful weighing at antenatal consultations proved invaluable in detecting excessive increase in weight and the possibility of developing toxaemia. In the cases referred for consultant opinion for toxaemia this was the first sign noted in the majority.

(6) There was one case of antepartum haemorrhage in which the condition of the woman deteriorated too rapidly for her to be transferred to the specialist unit. Blood transfusion was necessary, and rupture of the membranes produced a short labour resulting in a small stillborn foetus. The placenta was expelled with much retroplacental clot.

(7) Five patients were admitted to the general-practitioner unit for induction of labour for postmaturity.

Complications of Labour

(1) There was one case of obstetric shock which followed a normal labour, without any excessive haemorrhage, but it was sufficiently severe to warrant a blood transfusion. This woman had suffered from severe attacks of asthma since childhood.

(2) Postpartum haemorrhage occurred in three patients, in one of of which manual removal of the placenta and blood transfusion were necessary.

(3) One infant was delivered as an extended breech, with forceps

delivery of the aftercoming head.

(4) There was one case of prolapse of the cord in a para VI, with consequent stillbirth.

(5) Four cases of vertex presentation necessitated forceps delivery, three in primigravidae, and one in a para I. Episiotomy was done in each. There was delay in the second stage in two, foetal distress in one, and in the other the vertex was persistent in the occipito-posterior position and was manually rotated. Manual removal of the placenta was also necessary in this last case.

There was one multiple birth—twins who were not detected until labour commenced. These were uni-ovular twins but varied considerably in weight, one being 6 lb. 4 oz. and the other 3 lb. 4 oz. The smaller was transferred to the premature baby unit at the specialist hospital.

The Infants

169 infants were delivered, there being one case of twins.

There were 4 stillbirths, due to:

Primigravida		—	prematurity	1
Para	I	—	antepartum haemorrhage	1
	III	—	postmaturity	1
	VI	—	prolapsed cord	1
			Total	4

Two other infants were premature, and one of these died at 15 weeks in spite of care in the special premature baby unit for almost the whole of this period. There were five infants born at term with congenital abnormalities: hare-lip and cleft palate, multiple abnormalities, hydrocephalus, congenital pyloric stenosis, pseudo-hermaphroditism. The congenital pyloric stenosis was successfully dealt with, otherwise only the hydrocephalus survived the first three months of life. One infant died in the neonatal period due to congenital atelectasis.

Cases Originally booked for Confinement at Home or in the General-Practitioner Obstetric Unit, but transferred during Pregnancy or Labour to the Specialist Units

These numbered 32 according to parity as follows:

Primigravida		22	Para	III	1
Para	I	5		VI	1
	II	1		VII	2

(1) Nineteen of these cases were referred to specialist units during the antenatal period for the following reasons, the numbers accord-

ing to parity being shown:

Primigravida	Hypertension and toxaemia of pregnancy	7
	Diagnosis of placenta praevia at 36 weeks	1
	Postmaturity	2
	Antepartum haemorrhage at term	1
	Extended breech at 36 weeks	2
	Total	13

The case of hypertension was referred at 22 weeks and the cases of toxaemia at 33—34 weeks.

Para. I	Antepartum haemorrhage at 38 weeks	1
II	Antepartum haemorrhage, ? placenta praevia at 30 weeks	1
	Rhesus negative, antibodies present	1
	Total	2
III	Hypertension at 36 weeks	1
VII	Antepartum haemorrhage, placenta praevia and transverse lie at 37 weeks	1
	Transverse lie at 38 weeks	1
	Total	2

The types of delivery in this group of 19 were as follows:

Normal delivery	10
Extended breech	1
Forceps delivery	4
Caesarean section	4

Forceps delivery was carried out in two cases for delay in the second stage, once for foetal distress, and once after prolapse of an arm. Caesarean section was performed on three primigravidae and on one para VII for the following reasons:

Primigravidae	Extended breech in a woman married for 11 years
	Hypertension, high presenting part and hydramnios
	Placenta praevia with antepartum haemorrhage
Para VII	Transverse lie.

The infant delivered by caesarean section for central placenta praevia with antepartum haemorrhage in the primigravida proved later to be a spastic quadriplegia. The very small child delivered spontaneously at about 30 weeks, in the para II with placenta praevia, is a spastic diplegia with a minor degree of retrolental fibroplasia.

(2) The remaining 13 cases were sent into specialist units as emergencies in labour. The parity and reasons for these admissions follow:

Primigravida	Premature labour	5
	Premature labour and breech presentation	1
	Retained placenta	1
	Hypertension and high presenting part	1
	Primary uterine inertia	1
	Extended breech and primary uterine inertia	1
	Deep transverse arrest	1
	Total	11

Para	I	Uterine inertia and foetal distress	1
	VI	Postmaturity and rupture of membranes	1

As far as possible all cases of premature labour were admitted to specialist units so that the premature infants might be cared for at once in the premature baby unit.

In this group there were seven normal deliveries, three breech deliveries, one forceps delivery for prolonged first stage and foetal distress. The primigravida with deep transverse arrest was delivered by caesarean section. There was one stillbirth due to prematurity.

All cases which were originally booked for confinement in the general-practitioner unit but were transferred to specialist units either during pregnancy or in labour were returned to the care of the family doctor as early as possible in the puerperium. Many cases returned within 48 hours of delivery, relieving pressure on specialist beds, and ensuring the greatest possible rapprochement between the general practitioner and his own patients.

Summary and Conclusion

A series of 236 pregnancies and confinements is reviewed. There were 15 forceps deliveries, six breech deliveries, and six caesarean sections performed.

There were five stillbirths, and one infant died in the neonatal period. Seven infants were the subject of congenital abnormalities. Thirty-six cases were primarily booked to attend for antenatal care and confinement in specialist obstetric units. In 13 of these there was no obstetric or other clinical reasons for the booking, although three of the 13 later developed toxaemia of pregnancy. Two hundred cases were originally booked for confinement at home or in the general-practitioner unit, but in 32 of these cases it was necessary, either during the antenatal period or in labour, to transfer the patient to the specialist unit.

The general practitioner remained responsible for the care of 168 pregnancies, i.e., 71 per cent of the whole group. There were also ten cases which were included in the group primarily booked for specialist units which were normal in every way and within the scope of the family doctor. Five of these were booked on " social grounds " and five because of the expressed desire of the patient.

There were therefore 178 pregnancies and confinements with which a general practitioner could deal, i.e., 76 per cent of the whole group of 236 cases.

It would therefore appear that a general practitioner interested in obstetrics, who is willing to run his own antenatal clinics, could expect to deal with approximately 76 per cent of the pregnancies

and confinements in his practice. To do this he must be provided with the necess ary facilities and help, viz.: general-practitioner obstetric beds, facilities for laboratory investigations, and easy access to consultant help and opinion. With efficient primary and secondary classification of patients, the early detection of abnormalities, and early consultant opinion, the need for emergency services to be brought to the patient's bedside becomes infrequent. In the 168 cases dealt with by the general practitioner this had to be done once only, viz.: in a case of antepartum haemorrhage.

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A Heritage to Preserve. SAYERS, E. G., C.M.G., M.D., F.R.C.P., F.R.A.C.P., F.A.C.P. (HON.), F.R.C.P.ED. (HON.), D.T.M. & H. *Brit. med. J.*, 1961, **1**, 1057.

In his inaugural address to the British Medical Association meeting at Auckland, New Zealand, the Dean of the Medical School of the University of Otago had some interesting things to say about the qualities required of a general practitioner. Such a doctor must display kindness and courtesy, and be interested in what his patients have to say; he must know his job, and be able to judge when a second opinion is required, and also know which is the best consultant in each case; he should tell the truth, and should respect his patient's confidence.

Dr Sayers said, " I have thought a lot about this problem, and I must say I see no alternative in our day to good general practice. The conditions the patient requires will never be found in any out-patient department of the State, however efficiently run. Neither will they be found in a collection of specialists. It requires men of the highest calibre with at least two and preferably three years postgraduate training after qualification. It is a challenge to medical educators —especially, in my view, those responsible for postgraduate medical education. I regard general practice as one form of specialized practice; the training for it should be no less onerous and its status in the community should be equal to that of other specialities."