General practice and the future of obstetric care

ONLY 5.9% of deliveries are booked annually for general practitioner hospital care.[1] Antenatal care is considered by many hospital staff to begin at the hospital booking clinic. Only postnatal care is largely based in the community. A series of government reports, the most recent in 1984,[2] has encouraged the centralization of maternity care and an increased role for the specialist.

Behind these recommendations to government lay the unquestioned assumption that centralization and increasing use of technology in childbirth had led to improved survival rates of mothers and babies. Certainly, some scientific advance has improved outcome, for example the virtual elimination of rhesus isoimmunization, but there is now increasing evidence that place of birth has little influence on perinatal mortality rates and that the policy of centralization is not therefore based on scientific evidence. The perinatal mortality rate for booked home births in 1979 was 4.1 per 1000, compared with the national figure of 14.6.[3] The problem with maternity statistics is that women with risk factors, such as breech presentation, may be excluded from figures for birth at home or in smaller maternity units. Attempts which have been made to compare like with like suggest that general practitioner/midwife care is as safe or safer than specialist care for all women, except those at highest risk,[4] and that it results in less intervention.[5] The national Perinatal Epidemiology Unit in Oxford, having examined in great depth the evidence about place of birth, concluded: 'There is no evidence to support the claim that the safest policy is for all women to give birth in hospital' and 'The policy of closing small obstetric units on the grounds of safety is not supported by the available evidence'.[6] Alas, committees reporting to the Department of Health rarely based their recommendations on evidence, but more often on opinion.

General practitioners and midwives bring a different approach to maternity care than hospital specialists. Specialist obstetricians are calibrated for illness detection, general practitioners for normality.[7] General practitioners can provide continuing support from before pregnancy, throughout the antenatal period, during delivery, postnatally and, later, for the mother and her growing child. This is not a role that can be undertaken by any other health professional.

There is increasing pressure from women to pay greater attention to social and psychological factors during childbirth. Klaus[8] showed that constant human support during labour produced a significant decrease in perinatal complications and caesarean sections, and halved the duration of labour. Routine electronic monitoring does not reduce perinatal mortality[9] nor the incidence of cerebral palsy.[10] The value of technology, then, has been overstated, and we have, as a result, been blind to the great impact that psychological influences can have on the progress and outcome of labour.

Much will have to change if general practitioners are to provide intrapartum care again — especially in general practice itself. Newly trained general practitioners are opting out of obstetrics. Why is this, and what should be done about it?

There are problems. First, there is the question of facilities. Only 65 isolated maternity units remain in England and Wales,[1] and such units are vulnerable to criticisms about safety, even though almost all the evidence suggests that they are safe.[11,12] One recent paper[13] presented evidence that women delivered in urban maternity units fared better than women delivered in rural units, but the conclusions have been questioned.[14] It is not just lack of facilities that blocks general practitioner involvement at childbirth. Home birth requires no special facilities, yet the family doctor is the most likely obstacle to a woman's achieving her desire for a home delivery. Furthermore, integrated units suffer from lack of general practitioner involvement.

The second problem is the way that general practitioners receive their obstetrics training. The most potent effect of the six-month senior house officer experience in obstetrics is to frighten the general practitioner trainee — a bizarre result rivalled only by the effect parachute training has on its trainees. The future general practitioner spends his or her time exclusively in hospital, focusing on abnormality and surrounded by fear of litigation. There may need to be two kinds of obstetric list — and this is not a new idea — with extended training for a minority of general practitioners interested in intrapartum care. This training should focus on normal labour and should therefore be given by midwives, as it is midwives who have the greatest knowledge and experience of normal birth. Established general practitioners, especially women doctors returning to work, need a system to allow retraining. Course organizers should give trainees some evidence that there is a place for general practice maternity care.[15] Meetings of the recently formed Association for General Practice Maternity Care have exposed major problems with training of general practitioners.

The third problem is the poor rewards for general practitioners taking on obstetric care. The fee for intrapartum care is at present less than that for fitting an intrauterine contraceptive device, an amount which is quite out of proportion to the responsibility, time and disruption involved. Despite this, some general practitioners find intrapartum care the most satisfying aspect of family medicine.

The fourth problem is that of role definition. As Klein and colleagues have shown,[5] one of the advantages of general practitioner maternity care is the low level of intervention in childbirth. This, though, means that the very strength of such care is the lack of need for medical help. Where does this leave the family doctor? Advances in medicine generally have led us to believe that we help our patients by doing things to them, yet much of what is unique to general practice is not doing — it is listening, watching and being there. This is especially true at childbirth and, as our patients value these qualities,[16,17] so should we. Over 70% of women in our practice deliver in an isolated unit. Only a minority of women cannot be cared for by the midwife and family doctor.

Pre-conception care is most easily given by the professional who has had previous involvement with the woman planning pregnancy. This will usually be her general practitioner. Antenatal care may also be more effective when based in the community[18] and specialist care can be provided in such a setting.[19] At present, however, much antenatal and postnatal care is duplicated by general practice and hospital, is of doubtful value and presents conflicting advice. We need to discover what type of care is most effective.

The most vexed question concerns care at birth — who should provide it and where? There is growing acceptance among obstetricians and midwives that most women will have a 'normal' delivery and are best cared for by midwives. The government has made much of its 'aim to extend patient choice'[20] and a recent consumer survey confirms previous evidence that the centralization of maternity care is not liked by most women.[17] Yet isolated maternity units are still being closed. Home birth is frowned upon by most medical professionals, despite the fact that it has been shown to be as safe as hospital for those who

choose it (and it has been the policy in the Netherlands for over one third of births). Most women will continue to be delivered in large specialist units. There is good reason for creating alongside or attached units for low-risk women. General practitioners could then become the medical support for midwives. This would be welcomed by patients and result in less intervention. It could also be a welcome help to beleaguered consultants who may find junior staff in short supply in the future. Women at high risk would then benefit from greater consultant input.

We need a flexible response to maternity care, paying more attention to evidence and to women's wishes while paying less attention to entrenched beliefs and professional rivalries. Attitudes must change at government level and through all professional groups if we are to provide safe effective care that women want. The recently formed House of Commons Health Committee, at present holding an inquiry into the maternity services, has a great opportunity to lead the way. It is to be hoped that the committee will use the opportunity to promote necessary change.

GAVIN L YOUNG

General practitioner, Temple Sowerby, Cumbria

References

1. Smith LFP, Jewell D. Contribution of general practitioners to hospital intrapartum care in maternity units in England and Wales in 1988. *BMJ* 1991; **302:** 13-16.
2. Maternity Services Advisory Committee. *Maternity care in action. Part II care during childbirth (intrapartum care): a guide to good practice and a plan for action.* London: HMSO, 1984.
3. Campbell R, Davies IM, MacFarlane A, Beral V. Home births in England and Wales, 1979: perinatal mortality according to place of delivery. *BMJ* 1976; **289:** 721-724.
4. Tew M. Place of birth and perinatal mortality. *J R Coll Gen Pract* 1985; **35:** 390-394.
5. Klein M, Lloyd I, Redman C, *et al.* A comparison of low-risk pregnant women booked for delivery in two systems of care: shared-care (consultant) and integrated general practice unit. I Obstetrical procedures and neonatal outcome. *Br J Obstet Gynaecol* 1983; **90:** 118-122.
6. Campbell R, MacFarlane A. *Where to be born? The debate and the evidence.* Oxford: National Perinatal Epidemiology Unit, 1987.
7. Mathers N, Hodgkin F. The gate-keeper and the wizard: a fairy tale. *BMJ* 1989; **298:** 172-173.
8. Klaus M, Kennell JH, Robertson S, Sosa R. Effects of social support during parturition on maternal and infant morbidity. *BMJ* 1986; **293:** 585-587.
9. MacDonald D, Grant A, Sheridan-Pereira M, *et al.* The Dublin randomised trial of intrapartum fetal heart monitoring. *Am J Obstet Gynecol* 1985; **152:** 524-539.
10. Grant A, O'Brien N, Joy M-T, *et al.* Cerebral palsy among children born during the Dublin randomised trial of intrapartum fetal monitoring. *Lancet* 1989; **2:** 1233-1235.
11. Cavenagh AJM, Phillips KM, Sheridan B, Williams EMJ. Contribution of isolated general practitioner maternity units. *BMJ* 1984; **288:** 1438-1440.
12. Young G. Are isolated maternity units run by general practitioners dangerous? *BMJ* 1987; **294;** 744-746.
13. Sangala V, Dunster G, Bohin S, Osborne JP. Perinatal mortality rates in isolated general practitioner maternity units. *BMJ* 1990; **301:** 418-420.
14. General practitioner maternity units (letters). *BMJ* 1990; **301:** 664-667, 983-984.
15. Jewell D, Young G, Zander L. *The case for general practice maternity care.* Temple Sowerby: Association for General Practice Maternity Care, 1990.
16. Taylor A. Maternity services: the consumer's view. *J R Coll Gen Pract* 1986; **36:** 157-160.
17. National Council of Women of Great Britain. *Are we fit for the 90s?* London: NCWGB, 1990.
18. Parboosingh J, Kerr M. Innovations in the role of obstetric hospitals in prenatal care. In: Enkin M, Chalmers I (eds). *Effectiveness and satisfaction in antenatal care. Clinics in developmental medicine no. 81/82.* London: Heinemann Medical Books, 1982: 254-265.
19. Fawdry R. Antenatal care: a consultant's comments. *Practitioner* 1990; **234:** 352-356.
20. Secretaries of State of Health, Wales, Northern Ireland and Scotland. *Working for patients (Cm 555).* London: HMSO, 1989.

Address for correspondence

Dr G L Young, Association for General Practice Maternity Care, The Surgery, Temple Sowerby, Penrith, Cumbria CA10 1RZ.

Stroke and the carer

THE social and economic implications of stroke are great. Stroke is estimated to account for 6% of the total running costs of a hospital and is the major cause of chronic disability in the community.[1] Stroke is primarily a disease of the elderly,[2] the proportion of whom in the population is expected to rise by at least 15% in the UK over the next 20 years.[3] Recent projections have suggested that because of their greater age and frailty fewer victims of stroke will survive for long periods in a disabled state.[4] These demographic trends suggest that the burden of stroke is unlikely to alter in the future. For many years it has been accepted that physically disabled people should and could be cared for outside hospitals and only a minority of patients remain in institutional care as a result of their stroke.[5] It is estimated that over 80% of stroke survivors are living in the community one year after their stroke, of whom at least 25% are wholly dependent upon their immediate carer and a further 30% require regular support.[6] The future implementation of the government white paper *Caring for people*[7] will further increase the number of disabled persons in the community with implications for beleaguered carers who are at risk of psychological and physical morbidity.

In most cases the stroke patient lives with the principal carer who is usually either the patient's spouse, offspring or daughter-in-law.[6] It is estimated that up to 14% of carers give up their employment to look after the stroke patient, with obvious financial implications.[6]

The problems faced by carers of stroke patients may be directly infuenced by the type of neurological impairment or severity of disability in the patient. Intrinsic recovery following stoke occurs mainly in the first month.[8] However, functional recovery is more prolonged and is possible up to one year after the acute event.[9] It is not surprising that the continuing presence of aphasia can result in marital disharmony, including even cessation of sexual activity.[10,11]

Depression in stroke patients occurs in both the acute and chronic phase with a prevalence of approximately 15% in stroke patients at home.[12] Increased social and functional disability may result from depression.[13,14] Depression should be differentiated from emotionalism, which is characterized by an inappropriate tendency to tears or, less commonly, laughter which occurs suddenly. Symptoms of emotionalism are usually persistent and their management depends upon joint education of patient and family together with a consistent approach being taken by medical staff and carers to avoid inadvertent reinforcement of behaviour.[15] Depression following stroke usually responds to appropriate drug therapy,[16,17] however, phar-