

1. The doctor has authority because he/she knows his/her subject
2. The doctor has authority because of he/she is morally correct
3. The doctor has authority because of his/her personality
4. The doctor does not have any special authority

The majority of those questioned (60-71%) felt that doctors do have a special authority, which is based to a large extent on the doctor's knowledge. The opinions are less clear cut as to whether this authority stems from the doctor's moral position or personality; 27-41 and 14-48% felt this was a basis for doctor's authority. Statement 4 (above) was thought incorrect by 40-50%. There were only marginal differences between the sexes and between different age groups in respect to attitudes towards doctors' authority. A comparison between proponents and opponents of complementary medicine suggests that opponents more frequently believe in the authority of doctors in relation to its basis on knowledge (90% versus 58%) and moral correctness (60% versus 39%).

These data imply that doctors are perceived to possess authority which is based mostly on their knowledge. It has been postulated that medical authority is based on factors other than knowledge.¹ The present results suggest that the moral correctness combined with a charismatic element may also be contributors to Aesculapian authority. The growing popularity of complementary medicine might, in part, be an expression of the patients' search for practitioners who treat their clients with the empathy of a traditional healer rather than the technology of modern medicine.

E ERNST
M WILLOUGHBY

Complementary Medicine
University of Exeter
25 Victoria Park Road
Exeter EX2 4NT

TH WEIHMAYR

Ohmstraße 1
Munich, Germany

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Mothers as partners in antenatal care

Sir,
In Britain, antenatal care has evolved with little scientific basis. Consequently, we

endeavoured to develop a more rational system by holding a meeting for our current pregnant mothers, and those who had recently given birth, with professionals involved in antenatal care. The result is an antenatal clinic with the following aims:

- Antenatal care sensitive to the needs of women
- High standard clinical care with less clinical measurement
- A comfortable setting for a group of mothers where education takes place through discussion.
- Flexibility of timing and availability of care
- Availability of a wide range of therapies.

The focus of the clinic is a half-hour meeting for the mothers, the midwife and the doctor, sometimes with a guest facilitator. Some aspects of pregnancy are discussed. Women are encouraged to question the professionals and to share their own experiences and feelings. Afterwards there is informal discussion over a cup of tea. The midwife and doctor are then available for individual consultation. We have a standard of five attendances — at booking, twenty-two, thirty, thirty-six weeks and term. Mothers may consult if they feel the need at any time during pregnancy. They may attend the clinic as often as they like. The midwife or doctor may suggest attendances for clinical reasons.

We encourage women to take responsibility for themselves and for their births, and give them the information to make choices. They are encouraged to take control of their births in terms of position, pain relief, and management of labour by discussion among themselves and with professionals.

Mothers who have recently given birth give encouragement in breast feeding and the care of new babies. A cohesive support group for mothers is important both before and after the birth when new mothers can feel isolated. Mothers are encouraged to bring their new babies to the clinic.

Groups evolve informally in antenatal clinics when people are thrown together while waiting, but we have given them the recognition and structure which enables mothers to use our group more effectively. Giving mothers the responsibility of choosing when to attend may seem risky, but we find this improves attendance by previous defaulters. There has been an increase in home births, which may be a result of increased opportunity for discussion. Mothers who experienced home birth gave encouragement to those considering it.

Ultimately our clinic gives greater satisfaction to doctor, midwife and mother.

KEVAN THORLEY
TRISH ROUSE

Higherland Surgery
3 Orme Road
Newcastle
Staffs

Health care provision for people with learning disabilities

Sir,

As a former journalist with a particular interest in disability issues and now working in clinical practice, I am greatly concerned about the possible medical and social repercussions on people with learning disabilities and their families as a result of the reduction in general practice recruitment.

Over the past 20 years, apathy and disability¹ attitudes from general practitioners (GPs) towards people with learning difficulties have been extensively recorded^{2,3,4,5} as resulting in the subsequent mismanagement, inadequate care, serious illness and the non provision of health surveillance.^{4,5} A reduction in the number of entrants into general practice may lead to bigger practice lists in order to deal with the shortfall in cover. A consequence of this may be that there is an erosion of the presently inadequate health care provision for this vulnerable group of people.

It is also depressing to note that, in 1988, Bax⁶ records a disturbing proportion of young adults with a physical handicap that has been managed quite abysmally by their GPs. People with special needs and their families deserve equal treatment compared to the rest of the population.

MARTIN GABA

House surgeon
Department of Surgery
Crosshouse Hospital
Kilmarnock

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'Don't get it right, get it written'

Sir,

The increasing prominence of primary care should be reflected in national priorities for research and development. These are now being determined in relation to health need, and there is an opportunity for general practitioners, departments of general practice and primary health care teams to influence the agenda. One way to do this is to undertake and publish accounts of education, development or research projects in primary care.

Lack of confidence may inhibit the inexperienced to get their work published. In 1993 we held discussions with GPs, researchers, educationalists and primary care development workers in our department, regarding what stopped them from getting published. This arose from a realization that the number of publications did not reflect the range or quantity of work undertaken.

Three main areas emerged: personal doubts about the value of their work or writing, time management issues (such as deciding between priorities, finding time to read or write) and lack of supervision and support for writing. When asked what might help, the group discussed the need to be realistic about how much writing was possible, to start small, to develop a 'first draft' culture and for writing to become part of the daily routine.

A strategy was developed to raise the profile of writing, increase expectations and offer support. A writing group was set up to share successes, problems and expertise. 'Writing partners' were arranged for individuals with whom they could agree writing plans, and published material was displayed.

After 2 years, there has been an increase in the number of published articles (although other factors also contribute to this), and writing is now felt to be more of a central activity.

The comment, 'Don't get it right, get it written', coined by one of the group, perhaps reflects the growing enthusiasm for writing. While quality is important, our experience suggests that lack of confidence often prevents good work from being written up. Some are also dissuaded

by the limited scope of some journals which have not adapted to the growing range of projects in primary care. We wonder if others share this experience?

MARY SEABROOK
VIRGINIA MORLEY

Department of General Practice and Primary Care,
King's College School of Medicine and Dentistry,
London SE5 9PJ

CORRECTION: Julian Tudor Hart's letter in the August *Journal* ('Healthcare resource groups (HRGs): a casemix currency for GPs') was inadvertently printed with some text missing from the second paragraph. This paragraph should have read:

'We are given two histograms, both without numbers, confidence intervals, time periods, or any way of finding where they come from. The first compares orthopaedic HRGs for two hospitals with national means for length of stay. The second compares acute myocardial infarction rates per 1000 list size, apparently between six general practices. Both would provide a good teaching example of how never to present data to a serious, informed and critical audience.'

We apologize for any confusion this may have caused.



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