with the confidence to do so.

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History of GP obstetrics

I was delighted to read David Jewell's March focus column in the *BJGP*,[1] which has stimulated this communication.

I was a GP obstetrician from January 1947 to 1981. There has been increasing pressure from mothers, midwives, and health visitors to return to the days of high percentage home delivery where suitable. We are all aware of its advantages but they are much unsung.

In the period prior to the NHS in 1948, midwives were based in clinics run by the MOH (Medical Officer of Health) in conjunction with the MOH's assistants; they gave antenatal care and delivered babies at home. Should an emergency arise, the midwife would send for a doctor; one may or may not be readily available at that time, in which case time would be wasted by having to 'ring round' for help.

It was a time, early in my career, that 'fate' intervened and I answered such a call. On arriving I found the Superintendent of District Midwives (Miss D) and a trainee midwife had delivered the baby, but this was followed by severe post-partum haemorrhage. There was much loss of blood and an unconscious mother. I raised the foot of the bed by 18 inches, washed my hands quickly, and extracted the placenta with one hand, collected the lax uterus between both, gave ergometrine IV, and rigged a glucose saline drip followed by pre-constituted plasma (all of which I carried in my care).

While the drip ran I made a quick visit to the path lab where my helpful friends provided three bottles of suitably matched blood. Returning to the scene I ran this in and awaited events.

It did not take long for the mother to awake, take baby to the breast, and recover before secondary shock could supervene. Further nursing help arrived so, having 'squared off' the bedroom and recovered ourselves, Miss D and I sought relaxation in a local coffee house.

We both agreed that this sort of situation must not happen again. We met two or three times afterwards with ideas to present to the MOH and GPs. This 'incident' was the initiating factor to change. It did not take long for my GP colleagues to realise the need for an organised pattern of care throughout pregnancy, delivery, and post-pastum period.

The local medical committee formed an obstetric sub committee composed of a consultant obstetrician, a pathologist, three GPs, a paediatrician, and the MOH. Their recommendations emerged as follows:

- All mothers-to-be should 'book' their GPs and midwives in early pregnancy;
- They would examine the mother on alternate occasions throughout the pregnancy, monthly until the 28th week, fortnightly until the 36th, then weekly until delivery;
- Mothers would carry a maternity record card which would be filled in at each visit; and
- When labour commenced, the midwife would be informed and attend, the GP contacted so that he would attend.

In the 20 years or so when the local statistics were available, an average of 50% GP/midwife deliveries occurred at home, 25% by GPs in the local authority maternity home, and 25% by specialists in hospital. Perinatal mortality as reported by the MOH for the period showed that Ipswich statistics were equal to the lowest in the world.

I venture the thought that good organisation saves more lives than brilliance. It can be done; it should be done. We GPs owe it the families in our care.

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Home deliveries

I am aged 83 and was a GP for 34 years from 1954. I was on the GP obstetric list

in Bradford, Yorkshire and so had responsibility for home deliveries of my patients. I was appalled to see on the television yesterday that a report published in the *BJOG*[1] stated that babies born at home who needed to be rushed to hospital as emergencies were eight times as likely to die on transfer as average. The reason is that there are no obstetric flying squads available now.

When an urgent call came from a district midwife or GP to a maternity hospital for the flying squad, an obstetrician and a hospital midwife (and in later years a paediatrician) rushed to the mother's home by ambulance with bottles of blood and equipment. The baby and mother were treated and if necessary the mother was transfused before moving them to hospital.

Paramedics cannot resuscitate babies as adequately as paediatricians could in the mother's home and do not have the specialised equipment in which to transfer them to hospital.

It is important to consider the history of British maternity services. Before the 1930s it was accepted that women and babies could die in labour at home but in the late 1930s the National Blood Transfusion Service was established. About the same time Mr Harvey Evers, a consultant obstetrician in Newcastle, pioneered the obstetrics flying squads.

In 1958, Mr GW Theobald, a consultant obstetrician in Bradford, pioneered the early discharge of suitable mothers 24–28 hours after delivery. This made it possible for all mothers in Bradford to have hospital deliveries. As a GP there I thought it was a brilliant idea and it worked well. The perinatal mortality rate in Bradford fell from 45.8 per 1000 in 1956 to 31.8 per 1000 in 1962.

Every home delivery is potentially dangerous with a risk of the mother dying or of her baby getting brain damage or dying.

But the Chief Medical Officer, Sir Liam Donaldson, in his personal letter to me seems to think that they are safe. No surgical operation traumatically equal to childbirth would be done at home in 2008. It would be classed as malpractice. Nobody listens to old, retired GPs.

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Collaboration

The Focus column by David Jewell[1] and the editorial by Rosamunde Bryar[2] touch on the topic of shared responsibilities for care and the importance of responsiveness and good communication. This should be strengthened and facilitated by practice-based education and interprofessional adult learning, starting from the organisational and/or employer end of primary care.

It is important to get reciprocal collaboration, and focus on the initial preparation of doctors and nurses.

In Italy, for the last few years we have had a compulsory bachelor's degree for specialist nurses, opening up real opportunities for more joint learning and programmes at undergraduate level.

Sadly, the new bachelors don't seem to be getting better at communication and team-working and conflicts are arising in teams and departments. They regard themselves to be less considered than previous 'normal nurses' and at the same time they claim more autonomy, and do not follow, as before, doctors' therapeutic and decisional directives. This can have disastrous consequences on collaboration and healthcare development for patients.

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Corrections

In the April issue of the *BJGP* one of the determinants in Table 4 was incorrectly published in the following article:

> Uijen JHJM, van Duijn HJ, Kuyvenhoven MM, *et al*. Characteristics of children consulting for cough, sore throat, or earache. *Br J Gen Pract* 2008; **58(549):** 248–254.

The determinant 'reporting own health as moderate to poor' should be 'reporting own health as poor to good'.

The corrected version is available online.

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In the May issue, author details for the following article were shown incorrectly:

> Gorter K, van Bruggen R, Stolk R, *et al*. Overall quality of diabetes care in a defined geographic region: different sides of the same story. *Br J Gen Pract* 2008; **58(550):** 339–345.

The correct order of authorship is: Rykel van Bruggen, Kees Gorter, Ronald Stolk, Peter Zuithoff, Rob Verhoeven and Guy Rutten. Therefore, the article should be cited as:

> Van Bruggen R, Gorter K, Stolk R, *et al*. Overall quality of diabetes care in a defined geographic region: different sides of the same story. *Br J Gen Pract* 2008; **58(550):** 339–345.

Authors' details (qualifications and job titles) should have been shown as follows:

> **R van Bruggen**, GP; **K Gorter**, PhD, GP; **P Zuithof**, MSc, statistician; **G Rutten**, professor, PhD, GP, Department of General Practice, Julius Centre for Health Sciences and Primary Care, University Medical Centre Utrecht, Utrecht; **R Stolk**, professor, PhD, epidemiologist, Department of Epidemiology, University Medical Centre Groningen, Groningen; **R Verhoeven**, PhD, internist, Department of Internal Medicine, Gelre Hospital, Apeldoorn, the Netherlands.

The corrected version is available online.

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