THE EARLY CARE OF MOTHER AND CHILD

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IN ORDER to orientate oneself as a provider of maternity services and of some part of what might be called " Early Family Care ", in whatever direction the particular contribution is made, it is helpful to consider from a ' facts and figures ' point of view the present position and the indicated trends.

In 1962 there were 840,600 births in England and Wales. In the Blue Book *The Development of Community Care*[1], the Registrar General's Office gives the estimation that there will be 901,000 births in 1972. This estimate is based on the assumption that the upward trend, which began in 1956 and which resulted in 17.6 births per 1,000 living in 1961, will continue. (In the years 1936–1940 the birth rate was 14.7 per 1,000 living, in 1946–1950 18.0 per 1,000 living and 1951–1955 15.3 per 1,000.) This rise in the birth-rate has been accompanied by an increase in the demand for hospital delivery. The hospital plan for England and Wales[2, 3] assumed that 70 per cent of all confinements would take place in hospital and that mothers and babies would remain in hospital for ten days. In accordance with the Cranbrooke Report[4], 27,000 hospital beds were to be provided in 1975. This figure of 70 per cent was regarded as adequate to meet any increased demand, when assuming that there was a trend towards earlier discharge from maternity hospitals. The number of maternity-hospital beds available in 1961 was 20,473 as against 17,385 in 1949.

Miss D. C. Paget in an article entitled *Births and Maternity Beds in England and Wales in 1970*[5] suggested that if beds are available, the proportion of hospital births may reach 80–85 per cent of the total. Sir George Godber[6] has pointed out that the percentage of births taking place in institutions has steadily risen

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over the years, but that under the National Health Service the rise has been only from 61 per cent in 1950 to 66 per cent in 1951. (This is an average figure. The particular figure for Sunderland in 1961 was 40 per cent and for Southport 90 per cent. A great deal depends on the local housing situation and the population increase.) At the same time, the number of admissions to general-practitioner beds rose from 47,000 in 1953 to 102,000 in 1960. Although the number of home deliveries fell to a small extent between these years, the general practitioner was associated with 350,000 confinements in 1960 as against his association with only 200,000 in 1953. Whilst recognizing the increase in the number of births, it is not yet apparent whether this is due to earlier marriage or to the increase in the number of larger families. If it is due to earlier marriage, at some time in the future we may have too many hospital beds.

The local authorities' share of midwifery care has decreased during this time and now many clinics are used by midwives only for antenatal supervision and for the provision of health education and relaxation exercises and, perhaps, for the taking of blood for grouping and antibody estimation.

However much one may feel that the present maternity services can be improved, the fact remains that 30 years ago four mothers out of 1,000 died in childbirth and that in 1961 the figure was 0.27 per 1,000 live births. It is agreed that this rate can be further reduced if a patient whose history and parity indicates confinement in a fully equipped maternity hospital is not selected for home confinement. It will be noticed that ' selection ' is for home and not hospital delivery. This direction towards hospital confinement is occurring at a time when hospitals are desperately short of the trained staff necessary to attend properly to mothers and their babies. It is against this background that I would like to discuss the question of early family care.

The delivery of the baby is the most important episode in the midwifery story, but it is a brief one. The maternal and neonatal mortality and morbidity figures indicate how successful the conclusion of these episodes has been, but it is much more difficult to assess how much inconvenience, worry, unhappiness or even misery has been endured by a mother during her pregnancy and in the postnatal period. The family doctor and his midwife assistant provide a continuity of care which cannot be achieved in the consultant obstetric units, as most are organized at present. To the general practitioner the pregnancy represents a development, or if one likes,

another complication, in his care of the family as a whole. He knows the family, often their relatives and friends, their house and neighbourhood, their strength and weakness. He knows how much to say and what not to say; he knows what will worry a mother and what will not; he knows from past experience, in the case of multigravida, or from a reasonably shrewd anticipation with a primagravida, how much help the mother is going to need with her baby and how much help, or hindrance, she is going to get from relatives or friends.

For her part the mother knows her general practitioner and her midwife, and she expects, and I think receives, much more helpful explanation and assurance than she usually gets from hospital staff. Many general practitioners have been visited by worried mothers on their return from the hospital antenatal clinic. The summoning of the registrar or consultant to examine her and the whispered consultation at the end of the couch, often results for her in a pat on the back and a reminder to return to the clinic in a week or a month's time. No explanation of the need for repeat examination is provided and no reassurance that everything is going well, or simple explanation of some minor complication that may have arisen, is given. It is not realized sufficiently that any unusual item of attention, no matter how small it may be, especially to the uninitiated—the primagravida—may cause unnecessary worry for the patient if nothing is explained to her. The hospital doctor and midwife have much less time during the antenatal period to familiarize themselves with the mother's temperament and personality or to gain her friendship and confidence, than has the general practitioner and his assistant the domiciliary midwife. The best place for the delivery of the patient, however, may be in the consultant unit or in a general-practitioner unit closely associated with a consultant unit, the aim being to associate consultant, general practitioner and hospital and domiciliary midwife in such a way that the best of everything is provided as far as can be. Many consultant units have been described as ' baby machines ', turning out their products as fast as they can with a kind of cold, mechanical efficiency. The " get-them-delivered-and-out " policy, where it exists, has been precipitated by a disproportionate number of patients to staff. Too few staff are trying to cope with more and more mothers and babies in inadequate surroundings with inadequate facilities; that they have managed to do so well is something to be wondered at. The shortage of staff has often resulted in the lack of instruction of mothers in the feeding, bathing and

care of their babies and sometimes to difficulties in the training of pupil midwives. Many hospital midwives have expressed their feelings of frustration and dissatisfaction at not being able to provide the attention which they felt should be given to mothers and babies.

The establishment of general-practitioner units does not relieve the staff situation and, unless the unit is associated with a central maternity hospital, may even aggravate it, as staff in training will form a small proportion of the total, whilst trained staff may not be used to the best advantage. Careful forethought and innovation can do much to relieve the situation, for example the provision of hip-baths in the Malone Place General-Practitioner Unit in Belfast eliminated the time-consuming wash-downs after 24 hours following delivery. I have wondered how useful the provision of bidets would be in this respect. The replacement of baths by showers is believed to reduce the incidence of cross-infection. The provision of day space (again a feature of the Belfast General-Practitioner Unit) provides facilities for early mobilization of mothers and a place where talks, demonstrations and guided discussion can take place. Surely it is not necessary for ambulant mothers to eat in bed or immediately and precariously at the bedside. They could quite adequately and more comfortably manage most things for themselves if a small adjoining area was provided adjacent to the kitchen in which they could assist the domestic staff in light service duties. The provision of bathing facilities between admission and labour room has obvious advantages.

Adequate rest at night and at prescribed periods is very difficult to attain in the older maternity units. Curtains may provide long overdue privacy for nursing attention but are certainly no insulation against noise, and the separation of lying-in and postnatal accommodation from the labour ward is essential. The provision of less noisy appliances and furniture is still overdue in many units. As in all other branches of the health service the provision of these things is subject to financial restrictions.

The question of 'rooming-in' and 'rooming-out' is important but rooming-in seems nowadays to mean the keeping of 30 babies alongside their mothers for 24 hours a day, with the result that mother is usually awakened by everybody else's crying infant whilst her own is asleep. In a large well-staffed ward, baby should be moved out at night to give the mothers undisturbed sleep. The ideal is probably a three or four bedded lying-in ward with an attached nursery separated by a glass partition. The provision of small, one

or two bedded rooms does not meet the desires of most of the mothers to whom I have spoken as they do not like the enforced isolation which this arrangement brings.

It is surprising how often there exists amongst maternity-hospital nursing staff, and I suspect sometimes their teachers, and medical staff, a sort of simple-mindedness about baby feeding. Many apparently ignore the conclusive evidence that breast feeding does not result in better weight and health in the individual baby than does artificial feeding. Mothers are still chastised for their inability or reluctance successfully to breast feed and are made to feel that they are giving their babies an inferior start in life. Many mothers are just unsuited temperamentally and anatomically. Even more surprising is the assumption that partially established, i.e. breast feeding and complement feeding—that uneasy salve to the midwives conscience—or even apparently successful full breast feeding will be continued following discharge. How often the general practitioner gets the blame for suppressing lactation and stopping breast feeding which never had a chance of continuing in the first place.

" Successful breast feeding may be more difficult than artificial feeding, mother, but we will help you all we can if you really want to, and please do not think you are depriving your baby of something vital if you cannot and do not." These words should be exhibited prominently in every maternity unit.

Increased demand for admission and shortage of staff have reduced the time that can be spent demonstrating correct feeding methods and other facets of early baby care, such as bathing, care of bottoms, nails and hair.*

The appointment in some of the hospitals I have visited of specially trained and experienced staff to undertake instruction in feeding and general baby care is a step in the right direction, and their attendance at antenatal clinics to discuss baby feeding with mothers from an early stage of pregnancy is to be advocated. The mothers who decide on breast feeding can be helped with breast care and all can be shown how to prepare correctly an artificial feed. It is amazing the strange formulae that the fortunately resilient baby manages to put up with.

Hospital accommodation for the care of the premature and sick

*There is a widespread belief in Liverpool, and perhaps elsewhere, that baby's nails must be bitten off, and one often sees an otherwise spotless baby with long, dirty nails because mother is afraid to do this and has had no other advice. All kinds of concoctions are used in attempts to remove the seborrhoeic crusting on baby's head.

neonatal baby varies from the almost perfect to the almost non-existent in otherwise well-designed and well-furnished maternity units, provision for neonates is often inadequate. I suspect that some consultant obstetricians are not as interested as they should be in the provision of adequate neonatal care. I have seen babies cared for in sister's office whilst quite complicated procedures such as exchange transfusions have to take place in quite ridiculous surroundings.

I can never understand why nurses in warm baby rooms are expected to wear thick frocks and aprons, which are also worn in the arctic temperatures of hospital corridors. I wish that some realistic regulation could be put forward on this subject.

It is the premature baby that is often the most troublesome, following discharge from the baby unit. The establishment of a team of ' premature baby nurses ', as has been done in Liverpool, is of great help. These experienced and specially-equipped nurses make frequent home visits and do not cease to care for the baby until they are satisfied with its home progress.

As indicated above the general practitioner's share in obstetric care is not diminishing, whether he looks after the patient along with the district midwife and delivers her at home, or in a general-practitioner unit with a hospital midwife, or whether he just assists the antenatal and postnatal care of the patient who is delivered at hospital. It is obvious that any patient's desire to have her baby at home, apart from depending on the type of home, must be sub-ordinated to the history and parity of the patient.

Not all general practitioners are interested in the provision of general-practitioner units. Many are satisfied to share the antenatal and postnatal care of patients delivered in hospital and of supervising selected domiciliary deliveries, although the number of these is bound to fall with the provision of more hospital beds. General-practitioner beds may be available in an isolated general practitioner unit, or as a general-practitioner department closely associated with a consultant hospital or as an allocation of beds within the consultant obstetric unit. The right to use such beds may or may not be confined to doctors whose names are on the obstetric list.

The nature of control of general-practitioner units has aroused much discussion and argument. Allocated beds in a consultant obstetric-unit should obviously be under the control of the hospital department and I cannot envisage much dispute. For example, with the United Oxford Hospitals, who insist that patients admitted

to the general practitioner beds are the ultimate responsibility of the area department of obstetrics and must be referred for an antenatal appointment on booking and again at the thirty-sixth week.

It is the supervision of the separate unit which causes controversy. On the one hand, the general practitioner feels that he is capable of selecting suitable cases for admission, whereas the area consultant feels that he should be in ultimate control as he is responsible for care if an abnormality arises. One has heard the comment from the consultant that many general-practitioner units become the place where the general practitioner's friends and best patients are admitted for delivery, and that the hospital becomes a nursery for ' better-class ' mothers.

Perhaps a compromise has been achieved in Belfast where the Malone Place Hospital is governed by a committee of general practitioners with consultant and local-authority representation. The general practitioners themselves establish criteria for admission and supervise the running of the hospital. (A more detailed description can be found in the appendix.)

Communications in the midwifery services

When a mother is looked after throughout her pregnancy by the general practitioner and domiciliary midwife, and especially if the midwife attends the general practitioner's antenatal clinic, communications between all parties concerned in the care of a mother and child is at its best. There is a continuity of care which has great advantages for all. This also applies when the mother is confined in a general practitioner's unit where the general practitioner discharges the patient himself and continues to look after her in her home.

The increased number of confinements taking place in hospital has resulted in a separation, sometimes almost isolation, of those caring for mother and baby and unfortunately liaison between them is often unsatisfactory. Notification of the discharge of mother and baby from the hospital is often delayed and many days may elapse before the general practitioner is aware that his patients have returned home. Often the first indication is when he meets a mother pushing her pram whilst he is doing his round or when he is told by another patient that they have returned home from hospital. This delay may be due to the overworked hospital medical and clerical staff but I think more often it is the result of a basically poor method of notification. This problem is closely connected with the role of the health visitor (which is discussed later in more detail),

but it may be some days before she is able to visit the newly discharged patients and when she does the general practitioner may be unaware of her visit or her instructions, whilst on her part she can only have second-hand and often unreliable knowledge of any visit that the general practitioner has already made. Add to this the fact that the mother may also receive instruction from the doctor in the child welfare clinic and hospital follow-up clinic, and it can well be understood how she can be confused and that she and the baby may suffer consequently.

The notification of discharge procedure at the Royal Maternity Hospital, Belfast, was adopted following a meeting of hospital staff and general practitioners. A form containing brief details is taken home by the mother for passage to the general practitioner by a member of her household so that the general practitioner should know on the same day that the patient has arrived home. A more detailed letter follows by post. This procedure has been adopted in many hospitals and seems to be the most satisfactory, and it is good that a little bit of responsibility, that of seeing the notification is delivered to the doctor, should fall on the patient.

The health visitor should provide the liaison necessary between the hospital, general practitioner and medical officer of health factions of the midwifery services. She was originally intended to be a sort of domiciliary almoner working closely with the general practitioner. In many places she hardly ever meets the general practitioner and her duties are organized closely around the local authority and school clinics and her allegiance is to the local-authority doctor. I am aware that it is the local authority who pays her and provides the transport, but her present orientation is wrong and more imaginative use of her services can provide a valuable aid to hospital staff and to the general practitioner, with great benefit to the patient.

In the Royal Maternity Hospital, Belfast, liaison health visitors with the almoner, interview the patient on her first visit to the hospital antenatal clinic. They tell the patient of the ways in which they and the social services can help her. Health visitors attend the hospital ward rounds and besides being in a position to provide information on the home background to the obstetric consultant and his staff and to the paediatrician, they learn of each impending discharge and pass on the information to the local health visitor. The health visitor also attends at the neonatal unit and the background of every child is investigated so that no baby is discharged home until the health visitor is satisfied that home conditions are

satisfactory. There is in this hospital a comfortable and pleasantly furnished room providing accommodation for any mother and baby who are not doing well at home. They can be readmitted for a few days so that they may live under the close supervision of the hospital staff, and feeding and nursing instruction can be given.

The health-visitor general-practice attachment scheme has been widely discussed and publicized, and where established it works well. Unfortunately, there has been reluctance on the part of many local authorities to second their health visitors to general practices and not all general practitioners appear to be in favour. The attached health visitor provides a channel of communication with the local authority which is otherwise non-existent. Whether she works almost full time with group practices or only makes a weekly attendance at the general practitioner's antenatal clinic (where she has the opportunity to meet the district midwife), or children's clinic, her help is invaluable: she is after all a trained social worker which the general practitioner is not. Health visitors who have experience in working in general practice regard it as the most rewarding part of their work. The medical officers of health who have encouraged this scheme have done much to break down the barriers which have existed for years between the local-authority personnel and the general practitioner. The awareness of each other's contribution can only result in benefit for mother and baby. Unfortunately, we are very short of trained health visitors and this factor has been recognized in the ten year plan for the health and welfare services (1963) which recognized desirability of the close association of the general practitioner, the midwife, the home nurse, the medical and nursing staff of the hospital[1]. Increase in recruitment of domestic home helps has also been recommended.

The role of the child welfare clinic arouses much dispute but they do not appear to be running down as is the case with the local authority maternity clinic. Many general practitioners wish to provide infant health and feeding advice and to do immunization procedures themselves. They feel that the local authority clinic provides an unnecessary duplication and it is perhaps unfortunate that some local authorities make attendance at their welfare clinics a condition for the provision of cheap baby foods. Other general practitioners suggest that whilst their lists are large they have not the time necessary to carry out child welfare services themselves. The advantages of the general practitioner's doing this work for his own infant and child patients are obvious and the help of a health

visitor makes it much easier for him.

The midwife. The midwife's role in early family care is obviously the most essential. She delivers the greater proportion of babies booked for home delivery herself. The advantages to all, and especially the patient, of her attendance at the general practitioner's antenatal clinic cannot be stressed too much. With the increase in the number of hospital confinements some arrangement should be made for the domiciliary midwives to interchange with their hospital counterparts or under certain circumstances to attend the delivery of their patients in hospital units. One cannot imagine a more satisfactory or logical arrangement than that the team of midwife and general practitioner who have cared for the mother, perhaps also through previous pregnancies, should attend at her confinement in hospital. This arrangement should present little difficulty in the general-practitioner unit, but how much part the domiciliary midwife could take in the work of a consultant unit I do not know.

Early discharge from maternity hospital. Owing to the pressure on hospital accommodation, many mothers and their babies are being discharged before the end of the usual and recognized ten days hospital stay. Early discharge accentuates all the problems of communication which exist in the maternity services. The discharge of a patient at short notice and without prior warning, because of the sudden need for a bed for a new admission, often causes hardship for the patient. The home and family may be quite unprepared to receive her. Feeding may be poorly established and the general practitioner and domiciliary midwife may not receive notifications of her discharge soon enough to provide early help. Although the Central Midwives Board disapproves of early discharge because it causes difficulty in the training of midwives and because they feel that the arrangement may cause inconvenience and perhaps hazard for the mother and baby, and because they recognize reluctance on the part of the home midwife to act as a postnatal nurse, it must be realized that it is a widespread practice throughout the country and must continue for some considerable time. Much can be learned from the early discharge scheme which is operated at Bradford.

The Bradford maternity scheme. The Bradford early discharge scheme has been described in an article by Theobald[7] and a review of two and a half years progress appeared in 1961 (Douglas, Edgar and Horne)[8].

The impetus for the scheme was the relative shortage of antenatal

beds caused by the high incidence of pre-eclamptic toxaemia in the area served by St Luke's Maternity Hospital. More antenatal beds were provided by a reduction in the number of lying-in beds. This reduction was achieved by discharging suitable mothers and babies the second day after delivery.

The details of this scheme and associated recommendations to raise the standard of antenatal care in Bradford were worked out at meetings of a maternity liaison committee, where members included general practitioners, hospital staff and local authority representatives. The main details of this scheme are:

(*a*) During the antenatal period a home visit is made by the local domiciliary midwife to determine the suitability of the home for the early discharge of mother and baby, and the report is sent via the midwife supervisor to the hospital. The patient normally attends her general practitioner for her antenatal examination.

(*b*) The selected mothers are informed at the hospital antenatal clinic that they may be discharged home early and she can make the necessary domestic arrangements.

(*c*) Following delivery the selected mothers are sent to a special ward from the labour room, and if all has gone well, are informed that they will probably be discharged on the night before they are due to go home. Before discharge the mother is examined by an obstetric registrar and the baby by one of the paediatric staff. The baby must be healthy and weigh 6½ lb.

(*d*) Mother and baby go home in an ambulance accompanied by a hospital midwife, who ensures that the home is ready to receive them. If the home is unsatisfactory they may be brought back to the hospital.

(*e*) The hospital ward sister informs the supervisor of obstetric midwives of impending discharges. The supervisor informs the district midwife so that mother and baby can be visited on the day they arrive home.

(*f*) The mother takes home a form with information for the midwife. A special sterile outfit has already been provided for the use of the domiciliary midwife. The latter is responsible for informing the general practitioner of the patient's arrival at home.

(*g*) If mother and baby are not discharged within 48 hours they remain for 10 days.

To help in the running of the scheme additional hospital medical staff were engaged, and a medical officer with special experience in obstetrics was appointed by the local authority. To nurse babies and mothers at home additional part-time midwives were appointed, and domestic helps recruited.

It is unfortunate that because of the early discharge from hospital the home confinement grant is lost, and no financial aid is provided toward the cost of domestic home helps. This is in spite of the saving to the health service from the reduced stay in hospital.

The close co-operation of all concerned has made the scheme a success.

The misgivings about the risk to mothers and babies discharged early have not materialized and there has been no increase in the incidence of complications during the puerperium, and these mothers and babies compared with those confined and born at home[9].

Discharge at or near 48 hours enables feeding method to be established without interruption, and undoubtedly reduces the risk of infection to the neonate.

Similar early discharge schemes with modifications to suit local conditions could be adopted elsewhere. Anything is preferable to the haphazard pushing out of mothers and babies which takes place at present. Could not the patients selected for early discharge be confined in general-practitioner units associated with consultant hospitals, and perhaps delivered by the domiciliary midwife who has attended to them at the practitioner's antenatal clinic?

Summary and main conclusions

It is apparent that the building programme for new maternity units and the recruitment and training of midwifery nurses has not kept pace with the demand for maternity beds. This has resulted in many places in less careful early care of the mother and child than is desirable, and often in their haphazard and unheralded early discharge.

At the same time the number of domiciliary confinements is being reduced and few mothers and babies are enjoying the continuity of care which home confinement, supervised by the general practitioner and domiciliary midwife provides. Liaison between the trinity of services providing maternity care is being further strained to the detriment of the patients.

It is suggested that members of the almoner's staff and if possible health visitors should attend at hospital antenatal clinics. Their services should be more easily available to the patients both in and out of hospital. Their work should receive more publicity both in the hospital and in the general practitioner's surgery.

Vigorous efforts should be made to train more health visitors. A special category of social worker, who does not require the prolonged nursing training of the health visitor, should be recruited for district work. The employment of clerical assistants in hospital wards should be encouraged. Some of the social work associated with the ob-

stetric services could be undertaken by the district midwives after a little additional instruction.

Hospital procedures for the notification of discharge of mother and child should be reviewed and where found unsatisfactory should be the subject of discussion by the local maternity liaison committee. The representatives of maternity hospital staff, general practitioners and medical officers of health, could then together decide on the best procedure.

More emphasis should be placed on the instruction of mothers on baby feeding and infant care whilst in hospital. Day space should be provided which would serve as a class-room and resting and dining area. Where possible four or five-bedded units with an attached nursery should be built.

Properly organized early discharge provide a reasonable arrangement whereby a mother and her baby can enjoy the safety of a hospital confinement allied with a speedy return to the familiar care of their general practitioner and the domiciliary midwife. The pressure on the hospital staffs would be relieved, enabling them to concentrate on the patients remaining for ten days or longer. There would be enough of these patients to satisfy midwife's training requirements. If the mother in the early discharge unit could be delivered by her general practitioner and midwife, even more would be achieved.

Arrangements should be made for the mothers who have been discharged early to receive a proportion of their maternity grant, and where necessary financial aid to pay for domestic help. More domestic home helps should be recruited for this work.

A greater number of health visitors or social workers should be attached to general practices and more child welfare work should be undertaken by the general practitioner at his own surgery. Wherever possible the local district midwife should attend at the general practitioner's antenatal and postnatal clinic.

More emphasis should be placed on the work of the local liaison maternity committees. The committees should decide as a matter of urgency on the best type of general practitioner beds which should be provided for their particular areas.

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Footnote: During 1963 there were 856,368 births in England and Wales. On 20 December, 1963, the Ministry of Health issued G/H122/02. This publication indicated that the Ministry had become aware of the relative shortage of maternity beds and invited local discussion on the best utilization of the beds available. In effect it provided a recognition of the present need for early discharge from maternity hospitals.

Early discharge schemes are now in operation all over the country and liaison between all services is being improved. Reviews of the Bradford Scheme have not shown that there is any increased danger to the early discharge of mother or baby. Plans to establish a unit in Bradford in which district midwives could deliver their patients have been thwarted for the time being by administrative difficulties.

In the field of general practice co-operation between the district midwife, the health visitor and the general practitioner has increased and it is no longer unusual for the general practitioner to work with the midwife at his antenatal clinic and with the health visitor at his child welfare clinic.

The information on which this paper is based was largely collected during 1962 and I apologise for any statements rendered inaccurate by the passage of time.

APPENDIX

A description of places visited during the tenure of an Upjohn Fellowship

Malone Place General-Practitioner Maternity Hospital, Belfast

This 32 bed general-practitioner obstetric unit is established in what was formerly a gynaecological hospital. It is staffed by 22 fully-trained midwives working in eight-hourly shifts. There are no pupil midwives. Bookings are initiated by a letter from the general practitioner to the matron who fills out a co-operation card. This card is taken by the patient when she visits her general practitioner for antenatal examinations at his surgery. There is not an antenatal clinic at the hospital. The mother attends her own doctor for postnatal examination. Mothercraft and relaxation classes are held and laboratory facilities are provided. There are no antenatal beds and complications arising during pregnancy result in referral of the patient to the Royal Maternity or Jubilee hospitals (Malone Place is conveniently situated between these two hospitals). There are no emergency admittances and there is no premature baby unit. The aim is to deliver the type of patient who would be confined at home if the domestic and social situation were suitable, and no patient with a history of complications in labour is received.

A consultant clinic is held once a week and patients attend only at the general practitioner's request. Consultant care is available by rota. The patient with an abnormality in labour is transferred to the consultant obstetric unit at the above-mentioned hospitals for attention and then returned, if possible, to Malone Place and thence home. Forceps deliveries are carried out by some general practitioners at Malone Place but are not generally encouraged.

The general practitioner is notified at the onset of labour and 90 per cent of the deliveries are attended by general practitioners. The general practitioner pays postnatal visits until he discharges his patient to his continuing care at her home. This is normally at the seventh day after delivery. A health visitor attends at the hospital and talks to the mothers about her work and about the help she can expect. A physiotherapist is also in attendance.

The hospital building has been modernized and is well decorated and equipped. There is adequate day space for mothers and a nursery for the new infants. The kitchens are modern and have washing machines for clothes and dishes. Food for main meals is brought from a nearby general hospital and the patients are provided with individual trays and pots of tea from the kitchens. Each bedside locker has a control board for lights, radio and summoning bell, within easy reach of the patient. The small wards can be subdivided into bed spaces by curtaining. Hip-baths have been installed and are normally used twice daily by the patient. They are very popular and no wash-downs are given following the first 24 hours after delivery.

The patient is admitted to the receiving room where she is bathed and prepared, and then goes directly to the labour ward.

At the time of my visit in 1962, there were over 160 practitioners on the

hospital list who were able to admit their patients. There is no obstetric list in Northern Ireland and the only condition laid down is that the attending doctor is a member of a recognized medical defence society. The hospital is administered by the Northern Ireland Hospital Authority, and has no local authority connections. The unit is managed locally by a committee of four general practitioners and two consultants (one of whom is the professor of obstetrics at Queen's University, Belfast), and the chairman is a general practitioner. The general practitioners using the hospital attend a Sunday morning lecture held once a month at the Royal Maternity Hospital, Belfast, and are also invited to a monthly statistical meeting of all the maternity hospitals in the group. There is excellent co-operation between hospital and district midwives and the latter raise no objections to looking after babies and mothers discharged from the hospital.

Malone was opened as a general-practitioner unit in 1960. Another general-practitioner unit of about 32 beds will be opening in the near future in a building which was formerly a children's hospital. It will be associated with a new children's hospital at Dundonald.

The Churchill Hospital, Oxford

In March 1954, the Board of Governors made available three maternity beds for the use of patients under the care of general practitioners in the area. It was suggested that the patients admitted to these beds should be those normal cases whose home conditions were considered unsatisfactory for domiciliary delivery. Only doctors whose names were on the obstetric list were invited to use these beds.

The patients are the ultimate responsibility of the Area Department of Obstetrics and are referred for an antenatal consultant opinion on booking and again at the thirty-sixth week. All the facilities of the department are used by the general practitioner, but when a patient becomes abnormal or if complications occur a senior member of the medical staff of the department must be notified.

The general-practitioner beds have been increased and it was envisaged that by the end of 1962 provision for 144 admissions under general practitioner care would be made.

The Warren and Savernake general-practitioner units are also associated with the Oxford Department of Obstetrics.

St John's Hospital, Chelmsford, Obstetric Department

This is an 85 bed specialist unit in which resident undergraduate training and postgraduate general practitioner teaching is carried out. The St Peter's Hospital, Maldon, the W. J. Courtauld Hospital, Braintree and Burnham Maternity Home are general-practitioner units associated with the St John's Hospital Maternity Unit.

General practitioners from the area assist in the antenatal clinics at St John's hospital although there are no general practitioner beds in this consultant unit.