SOME OBSERVATIONS ON DOMICILIARY OBSTETRICS

A. E. DE LA T. MALLETT, D.S.C., M.A., M.D.
Wimborne

Domiciliary obstretics is at present in an unorganised state with three main forces (or services) for the most part pulling in different directions but having the same object in view—namely to produce an efficient and comprehensive obstetric service on a national basis.

These main groups are as follows:

(1) Major hospitals.
(2) General practitioners.
(3) Midwives.

In addition to these groups county council ante-natal clinics should be considered.

In many parts of the country the following incongruities may occur due partly to lack of facilities but also to the lack of co-ordination between these different services.

(i) Major hospitals, although accepting a patient for her confinement, ask the general practitioner to carry out the major part of the ante-natal examinations—the patient only being admitted when in labour or, if an abnormality requiring admission is detected, by the general practitioner.

(ii) A patient is only accepted by a major hospital for a first confinement or if an abnormal labour is to be expected.

(iii) Information gained about a patient in hospital (for example the blood group) is not subsequently communicated to the general practitioner, and this may at a future date necessitate duplicating an investigation.

(iv) Although a general practitioner may have conducted the ante-natal examination of a patient who is booked for delivery in a major hospital throughout her pregnancy, he is unable to attend her confinement either through distance, or more probably because no provision in the shape of a general-practitioner maternity bed is available.

(v) With regard to domiciliary confinements the illusory conception of "midwives' cases" and "doctors' cases" still exists with the following unfortunate results which must be considered ludicrous if considered with an impartial mind.

(a) Ante-natal examinations are carried out independently by the general practitioner and the midwife at different times and places without consultation.

(b) The general practitioner is often unaware that his patient is in labour—the first information he receives being either a call for assistance (perineal suture, episiotomy, forceps, etc.) or else the bald information that his patient has been successfully delivered.

(c) The general practitioner is often unhappy in his mind as to whether he can attend a "normal" domiciliary confinement without giving offence to a midwife who may consider the conduct of the case to be her responsibility.

(vi) The same remarks with regard to the relationship between midwives and general practitioners apply to an even greater extent when county council ante-natal clinics are considered.

The situation is even worse, however, as in this case the patient receives her ante-natal examinations from a doctor who is not going to attend her confinement under any circumstances—should any abnormality occur. It is the general practitioner (who may never have set eyes on the patient) who has to deal with the situation. I myself was once called to such a patient in the early hours of the morning with an obstructed breech presentation whom neither I nor the district nurse had ever seen before.

These are some of the disadvantages of the present situation. *The patient herself is the sufferer due to these incongruities*: What is the solution? It is apparent that the major hospitals are not in a position to supply a comprehensive maternity service for the women of this country—that is to say, the admission of any woman who so desires it for her confinement—nor in my opinion would this state of affairs be desirable. The general practitioners and midwives can neither of them without the other's help conduct domiciliary confinements.

The key to the problem lies in:

(1) Close co-operation between midwives and general practitioners.

(2) The provision of general practitioner maternity beds *with consultant backing.*

Midwives and General Practitioners

Midwives and general practitioners must realise that they cannot function independently and in their early training this fact should be strongly emphasized. The distinction between "midwives' cases" and "doctors' cases" should disappear forthwith and only the benefit of the patient be considered. All domiciliary cases should be the mutual responsibility of the general practitioner and the midwife, bearing in mind the ultimate responsibility that the doctor bears to his patient. With this end in view, I suggest:

(a) Ante-natal examinations should be carried out at the same time and place by the general practitioner and midwife.

(b) The general practitioner should invariably be informed when his patient is in labour, and his presence during labour or the actual delivery should not be construed in any way as a slight to the midwife, who indeed should welcome his presence.

These arrangements would bring immediate benefit to patient, midwife and general practitioner. The problem remains of the patient who either before or during or after labour requires admission to hospital. The general practitioner should have free access to hospital maternity beds where consultant services are available. Here he should be encouraged to undertake obstetric procedures within his capacity and under consultant supervision which he would otherwise hesitate to do.

By this means the general practitioner would receive valuable postgraduate instruction.

A New Approach to Bronchial Asthma

E. H. CLUER, M.R.C.S., L.R.C.P.

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Doctor Cluer points to the large number of drugs which have been used in the treatment of bronchial asthma. "There can be few general practitioners", he writes, "who have not tried some if not all of these drugs without meeting the frustration of a failure in response, in spite of a preliminary assurance to the unfortunate patient that this particular preparation is something 'quite different' ". He mentions the psychological element which is apparently present in most cases, but says that one can hardly consider a three-months-old baby in acute respiratory distress with asthma in the early hours of the morning to be suffering from some emotional conflict giving rise to an attack of asthma. In Dr. Cluer's opinion the rationale of successful therapy lies in the exhibition of a new drug, i.e., "new" in that it has not been tried for this particular patient previously. He claims that the psyche invokes an agency of central origin which inhibits the instigation of the asthma attack. This agency either replaces, potentiates or augments drugs used by the patient, but only because the confidence factor is established before ingestion or injection. Amphetamine sulphate was chosen as a drug capable of establishing confidence early in the patient's treatment, and thereby placing the psychic agency in control, before the use of drugs whatever their specific action. Dr. Cluer records ten cases with two failures which have been treated along these lines. His usual dosage has been from one to three tablets of 5 mgm. daily, and it appears that he carries on with this treatment indefinitely.