Reports

SUPPLEMENTARY MEMORANDUM ON

GENERAL-PRACTITIONER MATERNITY SERVICES

SUBMITTED TO THE COMMITTEE OF INQUIRY INTO THE MATERNITY SERVICES IN ENGLAND AND WALES (THE MINISTRY OF HEALTH) ON 31ST JANUARY, 1957.

The Position of General-Practitioner Obstetricians in a Maternity Service Controlled by the Hospital Service

(These observations are the result of further consideration of some questions addressed to the members of the College deputation on 13th December, 1956)

The College believes that the introduction of the general-practitioner obstetrician to the work of the hospital service must be regarded as fundamental to the well-being of the medical services of the country and to the development of first-class general practice. Much of the medical knowledge gained in the hospital service can reach the public through family doctors, who use it directly in the management of their patients and indirectly by transferring their patients to hospital for opinion and for treatment. This can be done completely and satisfactorily only if their own contact with hospitals is closely maintained. The great majority of general practitioners, at present, pay merely infrequent and informal visits to in-patient and out-patient departments. A high level of general practice is often found in those areas where the family doctor can take an active part in the work of the local hospital. Reorganization of the maternity service provides an unsurpassed opportunity for expanding this.

The General-Practitioner Obstetrician's Contract

General-practitioner obstetricians may contract to do obstetrics in two ways:—

(1) *Those who are booked by their own patients, or by the patients of neighbouring doctors*, for obstetric care either at home or in a unit with general-practitioner beds. The personal nature of this contract should be left untouched; it is one expression of the close identity of a general practitioner with a patient and her family. Whether the doctor is paid for this obstetric work by an Executive Council or by a Regional Hospital Board it should be on a " fee for service " basis. He must be professionally responsible for the case, with the consultant service behind him.

(2) *Those who hold posts in the Hospital Obstetric Service at any level*—clinical assistantships, the equivalent of S.H.M.O. posts, registrarships or consultant posts. In this position a general-practitioner obstetrician should be remunerated, as at present, on a sessional basis; his opportunities and obligations would be identical with those of general practitioners holding posts at comparable levels in other parts of the hospital service. If enough such posts were open to general practitioners, the attainment of a certain status of hospital appointment might ultimately replace the Obstetric List as it exists to-day.

Registrarships held by practitioners would, of necessity, be on a rotation basis to ensure cover throughout the twenty-four hours. They would provide opportunities for exchanges with registrars destined for consultant posts, who would thereby gain experience of the patients' background and a knowledge of general practice.

The provision of general-practitioner maternity departments in general hospitals, or in annexes attached to them administratively and medically, would bridge the gap that exists at present between general-practitioner midwifery and the hospital service. General practitioners would feel entitled to their fair share of responsibility for the direction both of these new hospital departments and of independent general-practitioner maternity units.

The General-Practitioner Obstetrician's Professional Relationships

These will be with:—

1. *His own patients and with neighbouring doctors' patients.*—This relationship should remain unaltered.

2. *Other patients who attend the hospital at which he is working.*—His general knowledge of home conditions and family problems would be a special contribution that he could bring to his work with these.

3. *Students and unestablished practitioners (including trainee-assistants).*—Closer integration of the midwifery service would improve teaching opportunities. Now that teaching hospitals have reduced their "district" commitments, students more rarely have experience of domiciliary work and of the training needed to adjust safe hospital technique to household conditions. General-practitioner obstetricians have, in fact, become the trainers of young doctors in midwifery in the home; this should not be taught in isolation but alongside that in maternity units and hospitals.

4. *His general-practitioner colleagues.*—Those with a particular interest in obstetrics would, between them, provide the twenty-four-hour service needed not only for their own cases but also for those

undertaken at the request of their professional neighbours and for obstetric emergencies in the area.

The risk of upsetting happy professional relationships with neighbouring family doctors would arise only if difficulty were experienced by the younger ones amongst them in developing their own obstetric skill. For this reason alone every opportunity should be made to provide these with obstetric experience, even if some have been unable to obtain a resident obstetric post after qualification. The need for such posts, at present, exceeds their number.

There will always be some family doctors who do not practise obstetrics regularly, but who wish to be present at a delivery for some medical, psychological or personal reason. The College considers that these should be encouraged to share the responsibility of a case with the general-practitioner obstetrician.

5. *Consultant Obstetricians.*—Excellent relations already exist throughout the country between general-practitioner obstetricians and their neighbouring consultant colleagues. Where the standard of general-practice obstetrics is high, relations are at their best and the consultants maintain their true position. The greater the opportunities for the family doctor to develop experience in obstetrics the sounder and more constructive is his use of the consultants' services for the management of anticipated abnormalities and of unforeseeable crises. When general-practitioner obstetricians are holding posts at different levels in a maternity hospital, or with beds of their own in a general-practitioner maternity department of a general hospital, or in an independent general-practitioner maternity unit, this relationship will develop to full advantage.

6. *Midwives and Health Visitors.*—General-practitioner maternity departments in hospitals or their annexes would be staffed by midwives seconded for regular periods from the main hospital obstetric service. Domiciliary midwives could, under some conditions, play their part in the work of these annexes, as well as in independent general-practitioner obstetric units. Health visitors, also, could visit both. This co-operation between family doctors, midwives and health visitors would be developed still further by meetings in the main hospital, in doctors' surgeries, in local health authority premises and in patients' homes. In this way family doctors, midwives and health visitors could contribute much to each other's work. Distance must necessarily limit opportunities for this relationship, but to an ever-lessening extent as suitable premises and an integrated organization develop.

Members of the Committee appointed by Council

ANNIS C. GILLIE (Chairman)

G. F. ABERCROMBIE	E. G. HOUSDEN
K. M. COBBAN	J. H. HUNT
R. HARKNESS	F. CHARLOTTE NAISH
E. B. HICKSON	J. C. T. SANCTUARY