PRACTICE OBSERVED

Practice Research

General practitioner participation in intranatal care in the Northern region in 1983

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Abstract

In 1983 a quarter of general practitioners in the Northern region of England cared for obstetric deliveries and half of these for a minimum of 10 deliveries a year. Most expected their intranatal work to remain at the same level or increase in the next 10 years. Most participating general practitioners did their own forceps deliveries and initiated inductions. Most out of hours deliveries were attended by the mother's own general practitioner or a partner. A quarter of all respondents had cared for planned and unplanned home births. Few were happy about attending them, but most would provide planned home care if urged to do so.

Introduction

Intranatal care given by general practitioners may range from taking nominal responsibility for the delivery while leaving most of the procedures to the midwife to personal care at every stage and undertaking appropriate intervention, such as induction or forceps delivery. The second half of our questionnaire on general practitioner obstetrics in the Northern region[1] was designed to examine what style of intranatal care was being practised by the general practitioners who were still providing such care.

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Method and results

The sampling and survey methods used to collect these data were described in our first paper.[1] The second half of our postal questionnaire explored the intranatal practice of those 159 general practitioners (26% of the 620 respondents) who used facilities for general practitioner deliveries. The percentages that follow relate to 159 respondents or slightly fewer when not all respondents answered the question. The differences cited in the paper are limited to those that were significant at or below the 5% level by the analysis described in our first paper.[1]

Fifty five per cent of respondents had attended 10 or more labours in 1982, but 45% had attended nine or fewer (table I): 44% usually tried to

TABLE I—*Number of labours attended by general practitioners in 1982*

No of labours	No (%) of general practitioners (n=150)
0-3	32 (21)
4-9	36 (24)
10-18	35 (24)
19-30	30 (20)
over 30	17 (11)

attend all three stages of labour and 56% normally attended stage one, 59% stage two, and 67% stage three. If informed during a surgery that a patient was ready to deliver 26% said that they would go to her straight away, 57% at the end of surgery, and 16% later in the day. General practitioners who were responsible for more labours were more likely to go at once.

Sixty three per cent of respondents said that they would do their own low forceps deliveries if required; 37% would hand patients over to a specialist. Users of isolated maternity units and units that were alongside consultant units were more likely to do their own forceps deliveries, as were general practitioners who held the diploma of membership of the Royal College of Obstetricians and Gynaecologists. Of those doing forceps deliveries, 29% had done three or more during 1982 (40 had done none, 26 had done one or two, 22 had done three to five, and six had done six or more, up to 18).

Sixty two per cent would put up a dextrose drip themselves if required

(in a prolonged labour with maternal ketonuria), 11% would do so after seeking advice from a specialist, and 27% would hand the patient over to the consultant unit. Thirty two per cent would put up an oxytocin drip themselves if it was needed to accelerate a slow labour, 15% would do so after seeking advice from a specialist, and 52% would hand the patient over to the consultant unit. The respondents' comments showed that this was sometimes the result of fixed hospital policy rather than a reflection of a general practitioner's confidence and skills.

Sixty one per cent of general practitioners would undertake some induction procedure for postmaturity rather than immediately refer the patient to the consultant unit (table II). Those who used general practitioner facilities that were integrated into a consultant unit were more likely to put up dextrose and oxytocin drips and do inductions when required rather than handing patients over to a specialist for these procedures. General practitioners who attended higher numbers of labours—more than 18 a year—were also less likely to refer patients to a specialist for induction.

TABLE II—*Preferred initial procedures for induction*

Procedure	No (%) of general practitioners (n=155)
Prostin pessary	28 (18)
Intravenous oxytocin	12 (8)
Rupture membranes	45 (29)
Refer to specialist	61 (39)
Other	9 (6)

TABLE III—*Out of hours cover provided by general practitioners for intranatal patients*

	Personally on call % n=148	Rota with partners % n=145	Rota with another practice % n=142	Deputising service n=151
Always	21	5	4	3
Usually	15	19	7	5
Occasionally	15	22	13	20
Never	36	42	76	68

The general pattern is for intranatal care to be concentrated in a few practices—that is, all general practitioners in the practice provide it rather than individuals in practices. A high proportion of respondents provided out of hours cover by being either "always" or "usually" on call or by a rota in their own partnership (table III). Deputising services were rarely used.

Twenty per cent of general practitioner obstetricians expected that the intranatal care in their practices would increase over the next decade, 61% thought that it would stay about the same, and 19% expected it to decrease. General practitioners who had graduated before 1960 were less likely (64%) than the remainder (88%) to expect it to increase or stay the same. Users of general practitioner facilities that were integrated in to consultant units were more likely to expect intranatal care to increase or stay the same than those whose units were alongside consultant units or in isolated units, despite isolated units being used more fully by the general practitioners who have access to them. The level of obstetric qualifications of the respondents made no significant difference to these opinions.

Seventy seven per cent of all respondents had undertaken no planned home deliveries in the previous three years, whereas the remainder had cared for up to 30 deliveries. Seventy eight per cent had undertaken no unplanned home deliveries, whereas the remainder had cared for up to six. Younger graduates (after 1970) were less likely than older ones to have done any planned home deliveries. General practitioners with the DRCOG or MRCOG were more likely than those without to have done some planned home deliveries.

Respondents were asked what their reaction would be to a patient who requested a home birth for a low risk second baby: 7% would agree, 58% would try to persuade her to go into hospital but provide care if she insisted, and 33% would decline to provide care. General practitioners who had the DRCOG or MRCOG were more likely than the others to agree to provide home care.

Discussion

Only about a quarter of respondents used general practitioner facilities for deliveries, and of these, only about half cared for over 10 deliveries a year, the minimum recommended by the Royal College of Obstetricians and Gynaecologists for general practitioners to maintain their skills.[2] Thus many of the general practitioners who are still willing and able to deliver babies are in danger of losing their skills as more and more patients at low risk are booked into consultant units. Since many of these general practitioners have a DRCOG this seems an inordinate waste of skill and training. One reason for the low number of general practitioner deliveries compared with the number of pregnancies for which they provide antenatal care presumably results from overzealous and rigid booking restrictions for general practitioner units at the beginning of the pregnancy.

When general practitioner facilities are alongside or integrated with consultant units it should be possible for potential high risk patients who receive shared care between the general practitioner and the hospital to be returned to general practitioner care for delivery if the potential problem does not arise—for example, a woman who previously delivered a small baby at term but in her current pregnancy has a normal sized fetus. Also, patients with problems in early pregnancy that have obviously resolved uneventfully, such as a threatened abortion, could revert to delivery by the general practitioner. There is also a prevailing tendency for low risk patients of general practitioners who are admitted during pregnancy for some abnormality, such as abdominal pain or severe urinary tract infection, to be followed up by the specialist unit and then delivered there, despite a complete recovery from the abnormal episode. Perhaps all bookings for specialist delivery should be carefully assessed at 36 to 38 weeks of pregnancy and in those where the prediction during labour is of a normal delivery without the need for technology the patient could be transferred to the general practitioner for delivery if he or she was prepared to undertake this.

Intranatal work can be rewarding and satisfying but makes demands on the general practitioner's time and commitment. Only a quarter of general practitioner obstetricians would go immediately to a patient who was ready to deliver if they were notified during a surgery. Though a general practitioner's reluctance to disrupt a surgery is understandable, a higher rate of immediate response would contribute to more continuity, to better cover for unexpected problems, and to confidence among patients, all of which should characterise the "general practitioner style" of intranatal care.[3] General practitioners who care for the highest numbers of patients in labour (over 18 a year) are most likely to go at once, which suggests that disrupting surgery is not an insurmountable problem for the general practitioner who routinely gives intranatal care.

The higher level of obstetric qualification among younger general practitioners did not lead to more enthusiasm for intranatal work. Nevertheless, among all respondents obstetric qualifications were associated with a higher degree of participation and greater confidence—for example, in carrying out forceps deliveries. They were also linked with a greater willingness to do home deliveries. This suggests that a general practitioner's obstetric training represents untapped potential that could make a valuable contribution to intranatal care for patients at low risk. Our data suggest that the more births that general practitioners attend the more confident they are to do forceps deliveries when required. Consultant units, however, should offer cover for forceps deliveries to general practitioners who do not want to do them. Perhaps the thought of being expected to do such procedures very occasionally frightens off general practitioners from giving intranatal care.

Much greater use was made of isolated units by general practitioners with access to them, and they were more confident about doing forceps deliveries than users of facilities alongside and in integrated consultant units. Consultant units should aim at offering a high degree of autonomy and responsibility to general practitioners who use delivery facilities alongside or integrated with them, to encourage greater participation by general practitioners.

Evidence of general practitioner commitment is in the low figures of those who use deputising services for out of hours cover

for intranatal care. These suggest that many general practitioners are available for their intranatal patients even when they refer other practice calls to a deputising service.

The expectations of general practitioner obstetricians for the future of their intranatal work showed little sign of hope, with 81% expecting it to remain at its present low level or even decrease. Younger general practitioners were more inclined than older ones to think that their obstetric work would increase, which gives some hope of an improvement in the future. Training by the Royal College of Obstetricians and Gynaecologists seems not to engender any optimism among general practitioners about doing obstetrics. Perhaps consultants unwittingly presented other deterrents: principal reasons given for expecting general practitioner intranatal care to decrease included "complex obstetric technology," "pressure from the RCOG," "local unit to close," "overlooking by consultants," and "unfavourable hospital attitudes."

Though little enthusiasm was shown for home births, roughly a quarter of general practitioners had to cope with planned or unplanned deliveries at home. Pressure from patients for more choices in childbirth has been gathering strength in recent years, including the option of a home birth where appropriate, and evidence for the safety of home births has been adduced.[4] Maintaining obstetric skills is essential for general practitioners to respond to this demand.

Conclusions

There remains a small core of enthusiastic general practitioner obstetricians who care for 10 to 30 deliveries each a year. They do occasional forceps deliveries and inductions and try to ensure that they or their partners are available to deliver their patients at any time of day or night. Their example shows the possibilities of general practitioner intranatal practice: personal and appropriate care for low risk patients. Their number, however, is dwindling because of overemphasis on consultant care and obstetric technology and not necessarily because of a lack of enthusiasm among general practitioners generally. Without the provision of more general practitioner facilities for deliveries and the active encouragement of consultant obstetricians, backed up by occasional cover, general practitioner intranatal care will continue to decline and may die out. This would be a sad loss for general practice and, more importantly, for women and their babies.

The funding for this study was provided by the research committee of the Northern Region Health Authority. The research committee of the North of England Faculty of the Royal College of General Practitioners spent much time and effort writing and piloting the questionnaire; we thank all the general practitioners in the Northern region who completed it.

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(*Accepted 29 January 1985*)

Vocational Training

Vocational training needs overhauling

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Ten years ago a rotating vocational training scheme was an exciting innovation in general practice. For the first time prospective general practitioners were to have three years in relative security while they acquired a range of skills, which at that time were thought to be appropriate for general practice. So successful were these schemes that the ideas encapsulated in them were eventually ossified into the 1979 National Health Service vocational training regulations.

The regulations, however, are now causing problems of their own, mostly because they impose an unnecessary rigidity. Thus there are problems in the vocational training schemes and problems for those doctors who are trying to construct their own training schedules. The rule that only 12 months will be spent in general practice is the first problem.[1] In any other specialty the doctor who goes into it is expected to do a six month house job to see if he or she likes it and is suited to it. This is entirely reasonable and means that much trainee effort and government expense may be saved. Furthermore, when selecting people for jobs one of the best guides to their performance is how well they have done in a similar job. At the moment anyone who is sensible enough to try a six month spell in general practice before starting on formal training is immediately disqualified from most vocational training schemes simply because the organisers of such schemes need to fill 12 month posts in general practice.

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Abandon training schemes?

Vocational training schemes are extremely popular, and I feel something of a cad when I suggest that we abandon them. The underlying difficulty is that when there is a series of six posts, only two of which are in general practice, the schemes are dominated by trainers, who are hospital specialists. These people will have had no experience of general practice except, perhaps, a few weeks as a locum in a rather scruffy set up 10 or 15 years previously. It is, therefore, difficult for them to understand what knowledge, skills, and attitudes we are trying to train for. It is even difficult sometimes to persuade specialists to release trainees

for the half day release course. Attempts to apply pressure may result in a threat to withdraw the post from the scheme.

Much of the experience in hospital jobs is not relevant to general practice, and sometimes trainees have to spend six months in a post when they may need only three. I heard recently of a trainee who spent six months in an ophthalmology job using a laser on patients with diabetes. At the end of the job she had not learnt how to remove a foreign body from under an eyelid.

There is a place for hospital training for general practitioners, but it is naive to imagine that people in training can fulfil service needs. Experienced general practitioner trainers know that trainees may sometimes create as much work as they save and that it is only in their last few weeks in practice that they begin to pull their weight. This is not because the trainees are unwilling to take responsibility nor because the trainers are unwilling to give it to them. It is because of their lack of experience: they are often unaware of the strategies of management available to them and they have not yet learnt the skills of identifying the patient's concerns.

If this is the case in general practice why does it not apply to hospital jobs? Any attempt to shorten the six month post to three months spent in different specialties is met with protests that only after three months are the trainees of some use to the department. This is absurd, for surely if a skill can be acquired in three months it would be better to have less expensive staff doing the job even if it takes longer in the first place to teach them how to do it.

A lot of luck is needed to get onto a vocational training scheme. The selectors tend to choose people who have done only preregistration posts because if they have done anything more they may be duplicating experience, thereby wasting a post. How can you possibly select somebody for a lifelong career in general practice when the only guide you have is what he or she looks like and a reference from their preregistration chief?

Recently a trainee asked for my help. She was of above average ability and had had extensive experience abroad but had also worked in Britain. She had done a year's traineeship and needed but four months more in one of the recognised posts. She said that she would be willing to work in any job that came up and would be prepared to work without pay. We then discovered that there were no suitable jobs available in the area as all the relevant specialties had mopped up their junior posts for vocational training schemes in their own specialty. I concluded that anyone who wanted to construct his or her own scheme had little chance of succeeding and that however bad the vocational training schemes for general practice are it is essential that we try to hold them together, or otherwise we would lose yet more jobs.

Our aims

What are we trying to achieve in vocational training? We seem to be aiming at producing a doctor who is barely competent to work in practice in 1985. Surely we are aiming too low. Most of these doctors will be in mid-career after the turn of the century, and the ideals that they set themselves now will dictate what is achieved in practice then. When I entered practice we were talking about open access to laboratories, about screening, and about teamwork, which is what we have got now. What will primary medical care be like in 20 years' time? My prediction is that it will move even further towards long term care and further away from crisis intervention. What we ought to be teaching are management skills; at the moment there is little room for that in the curriculum.

There is nothing mysterious about general practice. The qualities and skills of a good general practitioner, such as an ability to identify the patient's concerns and expectations, or the ability to use the consultation for anticipatory care, apply universally. It is difficult to teach these skills, but general practice is probably the easiest place to do it. Many more doctors should be allowed to work in general practice; taking on a six month appointment, for instance, which will not then preclude them from going into a formal traineeship.

It is time that we overhauled the whole system of recruitment in general practice. Has it got to be so unfair? Vocational training at the moment is unfair. Getting on to a vocational training scheme enormously increases one's chance of getting a practice. Getting a practice sets a doctor up for life. There are no easy solutions, but surely we could devise a better system. It need not cost money, but it will require a willingness to change.

Reference

1 *Statements of fees and allowances payable to general medical practitioners in England and Wales*. Para 38.5. London: Department of Health and Social Security, Welsh Office, 1977.

(*Accepted 7 January 1985*)

100 YEARS AGO

The following remarkable case was related by Dr. von Guggenberg, and the patient exhibited, at the last annual meeting of Bohemian physicians at Tetschen. On September 28th, 1876, he was summoned at two in the morning to see a woman, who was said to have cut open her abdomen. He found the patient lying in a miserable house, on a wretched and dirty bed, exhausted and bloodless, and only capable of making affirmative and negative signs. On removing a dirty petticoat which covered her, an incised wound was seen on the right side of the abdomen, passing downwards and inwards, from which a somewhat large coil of intestine protruded, the greater part of which, covered with dried blood, rested upon a dirty blood-soaked straw sack. Haemorrhage seemed to have ceased from every part of the wound, and the uterus was contracted to the size of a child's head. A fully developed, but dead, male child lay between the patient's knees. Clean linen was procured from a neighbouring house, and, with a piece soaked in oil, the protruded intestines were carefully wiped and returned, and the wound sewed up, the peritoneum being included with the skin. The incision was about 3½ inches long, and slightly S-shaped. It was dressed with a five per cent. carbolic solution, fixed with strapping, and the abdomen was carefully bandaged. By the afternoon, the patient was able to speak, and next day the history was taken. She had had seven children previously, four of whom had been born without medical assistance, two with forceps, and one after craniotomy. The pains began between September 24th and 25th, ceased in the afternoon, and came on again on September 26th, when the midwife stated that she felt the presenting head on vaginal examination. On September 27th, convulsions came on, according to the patient's account, accompanied by agonising pain and great distension of the abdomen, the movements of the child ceasing. The pain and distension became so severe that the patient determined to perform Caesarean section, of which she had heard. She, therefore, took a razor, and divided the skin slowly; she then made a second and a third incision; and finding the child not yet appearing, made another cut, which caused a large jet of blood to escape, and exposed the placenta; this she removed. One foot of the child came into view, which she seized and pulled upon until the whole of the body came through the wound, the head requiring the exertion of all her force. She divided the umbilical cord, laid the child (which she believed to be dead) beside her on the bed, and threw the placenta on the floor. She had passed neither urine nor faeces since September 24th. The progress of the case was very good; urine was passed on the afternoon of September 28th, but the first stool not till October 2nd. The pulse reached 120 on the day after the operation, but was never again so frequent; the temperature is stated to have been not very high, and, although there was a considerable amount of exudation from the wound, it had united by October 3rd. The patient soon returned to work, and has been ever since in perfect health. (*British Medical Journal* 1885;ii:393.)