Process and Outcome

Bookings at a GP obstetric unit: an exercise in peer review

MALCOLM AYLETT

British Medical Journal, 1977, **2**, 28-29

This decade is seeing the introduction of audit into medical practice on several fronts. Healthy self-criticism by the profession together with an administration increasingly interested in cost-effectiveness and rationalisation have emerged at a time when records have become more susceptible to analysis and review. The collection and storage of information by computer has made possible the examination of both organisational and clinical work on a far larger scale than before. All audit is threatening to the individual but is less so if carried out by himself or his peers. Peer review, a traditional and continuous process in hospital medicine, where several doctors share the treatment of a patient, is being introduced into general practice. The argument is that the Government, who pay the piper, will insist that the tune is at least audible. Audit is therefore inevitable and if not effected by the profession it will be imposed on us. This self-audit is essential if we are to continue to call much of the tune ourselves.

Obstetrics has for long been subject to audit. The outcome of childbirth lends itself so conveniently to measurement of the various indices of mortality and morbidity. Other features of pregnancy, such as the obstetric history, can also easily be subjected to methodical review, and this report is about the implementation of a booking policy based on patients' histories in a general practitioner obstetric unit.

Background

Greenways Maternity Hospital is a GP unit separate from the other community beds in a market town with a population of about 18 000. It serves a group of small towns and villages within a radius of some 9·5 km (six miles), though there is some overlap with other GP units, and is 24 km (15 miles) from the consultant units at Bath. Until the 1950s its 25 beds were barely sufficient but the falling birthrate and the booking of higher risk cases into the consultant units has led to a reduction of the beds in use to 13. There were 560 confinements there in 1970 and 259 in 1976.

General practitioners in the Bath clinical area have always had complete freedom to exercise their own judgment in deciding where their patients should be confined. They have worked in close and friendly co-operation with the consultant obstetricians, who have booked higher-risk patients into their unit and advised in cases of doubt. Each GP unit had affiliations with a particular consultant, who saw and operated on gynaecological patients locally and saw some antenatal patients but had no formal obstetric duties or clinics.

Several years ago the Bath consultants and general practitioners decided on a booking policy for their own beds in Bath, and this continues to be supervised jointly. GP beds there are within the consultant unit, and there are no problems. Some GP units outside Bath evolved a system whereby all new bookings were vetted at a consultant clinic. The general practitioners using Greenways Hospital met to discuss how they viewed developments in the area and, at a rather stormy meeting, decided that they wished booking decisions to remain unequivocally in their own hands.

Their far-sighted medical committee had, the year before, already agreed that the unit should have a booking policy. They had canvassed the views of user doctors and some sort of consensus was reached on what criteria contraindicated booking there. The general meeting therefore could decide without too much difficulty that they could embark on an exercise in peer review.

Corsham, Wiltshire
MALCOLM AYLETT, MRCGP, DOBSTRCOG, general practitioner

The action

A bookings subcommittee of three doctors, one changing every quarter, was set up to review the records of every patient booked. This committee depended entirely on information provided by the doctor on the booking form and the history taken at the first visit by the matron or senior sister. If confinement at the unit appeared, with reference to the prearranged booking policy, to be contraindicated the doctor was sent a letter giving the reason and suggesting a review of the booking. The general meeting had agreed that the medical committee should have no teeth, and it was hoped that this audit would be sufficient to lead to most unsuitable cases being booked into a more appropriate unit.

The outcome

Throughout the 1960s some of the more experienced general practitioners had continued to book higher risk cases into Greenways Hospital and even more recently a few examples of patients with conditions such as twins, breech, adverse age and parity, and poor obstetric history have continued to be confined there. The booking committee began its inspection of records in January 1975 and in that year 16 cases were referred back to the booking practitioner. In 1976 only eight were so referred, the fall-off continuing so that in the last quarter there was only one case (tables I and II). As the committee had

TABLE I—*Numbers of bookings referred back to the booking doctor in first two years*

1975				1976			
Jan-	Apr-	Jul-	Oct-	Jan-	Apr-	Jul-	Oct-
3	3	5	5	4	1	2	1

TABLE II—*Reasons for referring cases back to booking doctor in first two years*

Elderly primiparae	2
High parity	1
Recurrent abortions	7
Previous premature labour	1
Previous severe toxaemia	1
Previous complicated labour	7
Previous unexplained stillbirth	1
Previous dysmature infant	2
Twins diagnosed before booking	1
Fibroids	1

predicted, peer review alone was sufficient to reduce greatly the booking of unsuitable cases.

The sting

A review of the unit's work during the past two years also showed how little intrapartum obstetric experience the average practitioner now has. Even the local doctors who used no other unit had an average of only 15 confinements there a year. Of course, several factors, particularly the falling birthrate, are responsible for the decreasing use of the GP maternity unit but the classification of an increasing proportion of cases as "high risk" and suitable only for booking at a consultant unit is a major one. Our criteria at the moment are not the strictest and if we adopted the policy of the Royal College of Obstetricians in not booking nulliparae our work would be almost halved again.

By invoking a system of peer review, we appear to have changed our booking behaviour and reduced our obstetric responsibilities. Will we reach a point where many practitioners will carry out so little intrapartum care that they are unjustified in continuing this work? Will the GP maternity unit have so few bookings that its future is in jeopardy on economic grounds? In our efforts to be better doctors we may have accelerated our own demise as obstetricians and taken from the community a much valued resource.

I thank Dr Peter King, chairman of Greenways Hospital Medical Committee, for his advice in preparing this paper.

(*Accepted 9 May 1977*)

Clinical Topics

A haematuria diagnostic service

A G TURNER, W F HENDRY, G B WILLIAMS, D M WALLACE

British Medical Journal, 1977, **2**, 29-31

Summary

In a haematuria diagnostic service, covering experience with 95 patients, 12 new cases of cancer of the bladder, one of cancer of the kidney, and one of cancer of the penis were identified—all at an early stage. Patients presenting with haematuria were investigated rapidly without disruption of the routine work of the urological unit. Patients who identified the symptom and sought advice early were given a definite diagnosis quickly, and treatment for any malignant disease was started early. The delay that undoubtedly endangers patients' lives has been considerably reduced by this service.

Introduction

Patients readily recognise haematuria and usually seek medical advice early. Wallace and Harris[1] showed that delay in diagnosis of patients presenting with haematuria produced a notable detrimental effect on the prognosis for those with infiltrating bladder tumours. Figures from the South Metropolitan Cancer Registry showed that if treatment was started within one month of the onset of bleeding the crude three-year survival was 60%, whereas with a delay of one to six months the crude three-year survival was reduced to 25%.

The causes of delay could be divided into: (*a*) delay in the patient seeking medical advice, (*b*) delay due to the general practitioner—from patient first seeking advice to hospital referral, and (*c*) delay at the hospital—either before appointment at outpatients or on the waiting list for admission. In fact, most patients reported their symptom quickly, and few doctors hesitated to refer them for specialist investigation. By far the greatest single factor in delay was at the hospitals. Therefore the responsibility for more efficient diagnosis and treatment rested with the hospital, its appointment system, and its arrangements for investigation and admission.

Clinical methods

A haematuria diagnostic service was started at the Royal Marsden Hospital as a pilot study specifically to try to reduce the hospital delay. Two facets of the problem were considered.

Referral to outpatients—General practitioners were circulated with an explanatory note and a supply of referral cards. These cards (fig 1) were filled in by the practitioner on one side with basic details, and on the reverse side there was a map of the location of the hospital to enable patients to reach the hospital easily. General practitioners were asked to send the patient straight to the outpatient department of the hospital (9·30 am to 3·00 pm, Monday to Friday). On arrival at the outpatient department, the patients were seen immediately by either the lecturer or senior house officer of the urology unit.

Investigation and admission—The doctor took a history, examined the patients, and arranged for urine bacteriological and cytological studies, chest radiography, and intravenous urography to be performed. A return appointment was made for the next outpatient clinic, when the patient was seen by the consultant with all the basic investigations completed. An admission date was then arranged, usually for cystoscopy under general anaesthesia on the next operating list. The time from arrival at the general practitioner to admission to hospital was thus reduced to a few days.

Urological Unit, Royal Marsden Hospital, London SW3 6JJ
A G TURNER, BSC, FRCS, lecturer in urology
W F HENDRY, CHM, FRCS, consultant urologist
G B WILLIAMS, MS, FRCS, consultant urologist
D M WALLACE, MB, FRCS, professor of urology, University of Riyadh