greatly assists the integration of hospital and local authority medical services.

Conclusion

At a time when the whole future of the small hospital is in the balance it is hoped that the foregoing survey helps to illustrate the extent to which local services can be developed, not with a view to achieving complete independence, but rather in closer integration with the larger hospitals and universities. Decisions on the degree of expansion which can be justified must be taken by careful appraisal of the interests of the patient on the one hand and the question of expense and efficiency on the other. Where a surgical unit of the type described is established in an area which is remote from the nearest large centre, and subject to irregular transport and communications, one must face the fact that the standards of staffing and equipment required may impose a level of expenditure which is out of proportion to the population served. The criteria employed in assessing such financial outlay are therefore entirely different from those which apply to the large hospital or to the small hospital which has easy access to the central complex.

I wish to thank The Shetland Times, Ltd. for permission to reproduce Fig. 1, which is taken from *The Islands of the North*, by W. P. L. Thomson, and Mr. Dennis Coutts for Fig. 2.

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General-practitioner Obstetric Beds in a Consultant Unit

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Oldershaw and Brudenell (1968) described the use of obstetric beds in a consultant unit by general practitioners. The area of London with which they dealt is a little to the south of our similar scheme based on the Lambeth Hospital but virtually abutting upon it. With the help of Dr. Oldershaw a similar use of beds in a consultant unit was devised, and because of his help our scheme in the St. Thomas's group of hospitals is almost identical with the one described by Oldershaw and Brudenell, and so the description will not be repeated.

The Board of Governors of St. Thomas's agreed to make available to general practitioners in the area four beds in the consultant unit at the Lambeth Hospital. At first it was thought that since most of the bookings would be on social grounds a ten-day stay might have to be budgeted for. Therefore it was felt that the four beds might cope with about 120 patients per year. General practitioners in the area were written to and asked if they could estimate how many deliveries per year they might be willing to deal with in hospital. Allowing for 150 deliveries per year we were vastly oversubscribed. So until we knew how the scheme was going to work it was limited to 12 doctors, whose total estimated deliveries would come to about 150 per year. They were offered and accepted an honorary contract with the Board of Governors.

Results

The scheme started in March 1966, and so has now been running for two and a half years. During that time we might have expected to have had 300 childbirths supervised by general practitioners, and this would have been a minimum figure. On a five-day stay it could have been doubled. Even those booked mainly on social grounds do not stay longer than six or seven days. In fact there have been only 86 deliveries of patients booked for general-practitioner beds in the two and a half years. This is a bed occupancy of about one patient every ten days, giving a rate of about 25%. The overall bed occupancy in the unit is about 80% to 85%, and over the same period about 4,500 women were delivered.

The antenatal care of all these 86 patients was scrupulously carried out and left nothing to be desired. The communication card carried by the patients made for very easy transfer of the patient from one doctor to another.

Of the 86 patients 41 were visited at some time during the first stage of labour by their booked doctors, but 20 of these visits were made by one man. He looked after 47 patients out of the 86, so for visiting he scored 42%, while the others between them scored 53%. However, the same doctor was present at the delivery of 22 of his 47 patients and so scored 47%, while his colleagues were present at delivery in 11 out of their 39 deliveries, a score of 28%. These scores are all increased slightly when account is taken of the fact that five women were admitted to hospital in the second stage of labour, when there was no time for the doctor to be called.

In nine cases there was great difficulty in contacting the doctor, and in four other cases the doctor told the labour ward staff that he was not to be called further about his patient. Especially with the increasing use of emergency call services it is often difficult to get into touch with general practitioners on their days off. A barrier between them and the hospital is interposed first by the G.P.O. telephone service and a second by the call service. Only the utmost persistence will make these two bodies divulge the telephone number of a doctor who does not wish to be called, and search through the telephone book shows that some are "ex-directory."

Discussion

There was great initial enthusiasm for the scheme, which was shared on all sides. Both general practitioners and consultants know each other and share confidence in each other's abilities, and nothing said here is to be interpreted as an attack on those general practitioners who belong to and are most welcome in the consultant unit. But our experience seems to show that the local general practitioners overestimated their needs at the beginning, and they underestimated their difficulties in getting to see their patients during labour and at delivery. There are many valid and good reasons for this, and this report is in no sense intended to be a complaint, for the hospital staff have been ready and willing to look after and deliver the patients, none of whom has suffered, since the co-operation between the general-practitioner service and the hospital has been so close and the results for both mothers and babies have been so good that comment upon them is superfluous. Moreover, there has been the inestimable benefit to these mothers of continuity of antenatal

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care close to their homes and of visits to them by their doctors while they have been lying-in. And no doubt their postnatal care has been so much the better for the close personal attention of their own doctors. None of this is in serious doubt, but the idea that general practitioners are willing and able to care fully for their patients in labour, when they know that these patients will be cared for by the hospital staff in their absence, needs careful appraisal. The amalgamation of the tripartite obstetric service is ardently to be desired, and certainly so by all concerned in our area of London, but each branch must know what it can bring to the union so that the service can be properly administered. Pious hopes of what each might do are not enough.

Conclusions

Some of the teething troubles encountered in an attempt at uniting the general-practitioner obstetric service with that of a consultant unit are described. On the whole the union works well and offers great advantages to a few women. The object of this paper is to define a little more clearly the respective roles of the general practitioner and the hospital in the scheme, so that each may supplement the other in the provision of service to the patient.

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CONFERENCES AND MEETINGS

R.C.G.P. Conference on Examination Methods

Opening a Conference on Examination Methods at the Royal College of Physicians held on 14 and 15 November Sir MAX ROSENHEIM, P.R.C.P., said that the best method of examination had yet to be found. The first session, with Dr. JOHN HUNT, P.R.C.G.P. as chairman, was devoted to "What is to be Tested: Knowledge, Skills, and Attitudes." Dr. ANDREW SMITH (Newcastle upon Tyne) said that general practitioners assessed the quality of their colleagues gradually through professional and clinical contacts and rated them good, bad, and adequate. He described profiles of two adequate general practitioners: one was a personal doctor skilled in communicating with patients but limited by bad organization and lack of up-to-date clinical knowledge; the other was well organized and worked in modern group-practice premises but lacked skill in communicating. A good general practitioner needed the best qualities of both, as well as several others—notably that of progressively acquiring knowledge by attending suitable postgraduate courses and systematically reading medical journals.

Dr. IAN RICHARDSON (University of Aberdeen), defining general practice as primary, personal, comprehensive, continuous family medical care, said it involved a wide range of skills. Clinical skills included competence in psychological, sexual, preventive, and welfare medicine as well as in creating and using personal relationships. An examination might test clinical techniques but should also test applied learning capacity. Organizational skills included record keeping, which provided the facts to be marshalled in favour or against decision and action, and use of the community health team. Skill in epidemiology—where the distribution, determinants, and prevalence of different diseases by age, sex, and social class were studied—was essential for the "new general practice."

Attitudes

Dr. P. S. BYRNE (University of Manchester) said that a general practitioner's performance depended on his attitudes, his feeling for or against things, which implied an interplay of emotion, knowledge, and action. Attitudes to patients, to colleagues, and to professional life would be generally agreed. They included courtesy, compassion, and sympathy to the patient considered as a whole person in social and clinical terms; a favourable attitude to preventive medicine; early diagnosis; continuing care; health education; and appropriate delegation to members of the health team. Doctors needed to define attitudes to the dying, the chronically incapacitated, and to the role of special interests and work in hospital. Each group of attitudes, which would vary in strength from doctor to doctor, needed to be measured so that they could be tested objectively not only in trainees but (because attitudes were taught by example, not precept) in their teachers. Since much general-practitioner teaching would take place in hospital by teachers with different attitudes there must be continuous dialogue between the trainee and general practice.

Dr. GRAHAM BULL (Northwick Park Hospital), speaking on the essay type question, said that marking was very inaccurate. It was more so in papers with long questions, a larger number of short questions providing a less inaccurate assessment of a candidate. Analysis of marking at schools and universities showed that only mathematics and chemistry papers could be marked objectively. He had analysed the results of the final M.B. examination at Belfast, and had found that the marks varied not only from one examiner to another but with the same examiner marking the same paper on two different occasions. This examiner error was inherent in essay-type questions, whose main value was educative in that they stimulated the student to learn what he might be asked in them.

Oral Examinations

The oral examination, D. H. J. WALTON (University of Edinburgh) said, had been less studied than other procedures despite its hallowed place in medicine. It did test verbal fluency, but there was no correlation between marks and personality factors. He described the Harvard experiment, where observers had monitored teams of examiners examining students. Despite good briefing there was no consistency among examiners: some teams marked high, some low; the marks improved in the afternoon; teams varied greatly in their assessment of a particular student, and members of the same team differed from each other. Over two-thirds of the questions in oral examinations tested recalled stored information and less than a third tested interpretative skill and problem solving. This type of examination could be influenced by students' strategy: when stumped, an appeal to higher authority was a better strategy than either a prolonged pause or an expression of anger with the examiner. Nevertheless, orals could—if examiners were properly briefed after prior definition of the abilities to be tested—test some abilities better than other techniques: attitudes, for example, if they were specifically defined. In the discussion which followed it was generally agreed that the final medical examination was a bad test of student attainment and a poor predictor of subsequent professional performance.

LORD PLATT OF GRINDLEFORD, chairman of the session on "How Does One Test?" said that a R.C.G.P. examination must eliminate the inadequate rather than define the outstanding doctor. Speaking on the multiple-choice question, Professor GEORGE SMART (Newcastle upon Tyne) said it was free from examiner bias and tested consistently: the same mark would be reproduced on remarking, and papers of similar standard and subject given to the same group of students would rank them in the same order. Multiple-choice papers could test a very wide range of knowledge and were easy to mark. Though it was difficult to frame the questions, they could be analysed after examinations, improved, and used on subsequent occasions. In practice most papers tested mainly factual knowledge, but it was possible to test reasoning power though not the power of self-expression.

Dr. J. D. E. KNOX (Edinburgh), speaking on "Cores of Knowledge," emphasized the need to define the body of knowledge to be tested, which was difficult, because there was no formal limit to the general practitioner's field of work. The latter included attitudes as well as skills in clinical medicine, community medicine, and practice organization,