Obstetrics and gynaecology for general practice

ROYAL COLLEGE OF GENERAL PRACTITIONERS

A discussion document

A Working Party was appointed by Council with the following terms of reference:

1. To examine and report on the functions and educational needs of the general practitioner in obstetric care.

2. To consider and report on the educational needs of the future general practitioner in relation to medical gynaecology and contraception.

We have focussed our attention mainly on obstetric care because the place of obstetrics in general practice continues to be the subject of change and debate. The difficulties in arriving at a coherent educational policy were last demonstrated openly in the reports of the College Obstetric Working Party (Royal College of General Practitioners, 1973) and the Joint Working Party with the Royal College of Obstetricians and Gynaecologists (Royal College of Obstetricians and Gynaecologists and Royal College of General Practitioners, 1974). At that time the critical issue of whether the provision of antenatal and postnatal care should be part of the routine responsibility of the general practitioner or a matter of personal choice was not resolved.

We awaited developments on three important matters before reporting. First, we wanted to see the Vocational Training Regulations so that our recommendations on training could be related to current professional policy. Secondly, we looked forward to joint visiting between the RCOG and our College as we felt these visits could influence the nature and quality of the clinical experience offered in hospital training in obstetrics and gynaecology. Thirdly, we wanted to be clearer on the profession's attitude to clinical audit.

The RCOG has now invited our College to form a new Joint Working Party on training for obstetrics and gynaecology in general practice. We have reached conclusions which could assist the coming discussions.

Obstetric care in general practice today

The present position

The Hospital Inpatient Enquiry (DHSS, OPCS and Welsh Office, 1973-1976) shows that the trend towards hospital maternity care continues. By 1976, home confinements were down to 2·4 per cent in England and Wales, and four out of every five discharges were from consultant units. Deliveries in hospitals without obstetric departments (NHS 'A') had fallen to 7·8 per cent although there is evidence (MacFarlane, 1979) that in obstetric hospitals with integrated general practitioner maternity units the numbers are increasing. The trend toward progressively decreasing involvement of general practitioners in intranatal care is further confirmed by examination of general practitioners' claims to family practitioner committees for maternity services (DHSS Forms SBE 504) (DHSS, 1980). This shows (Table 1, Figure 1) that whilst a large and increasing number of claims are submitted for antenatal and postnatal care only, the proportion which include care during the confinement was, by 1979, only 15·4 per cent.

Several family practitioner committees (1980) kindly helped us to form some idea (by the analysis of claims for maternity services made during 1979) of the number of doctors who are still involved in intranatal care (Table 2). These figures may not be representative of the

Figure 1. *Trends in general practitioner obstetrics (England and Wales)—claims for maternity services (percentage of all births).*

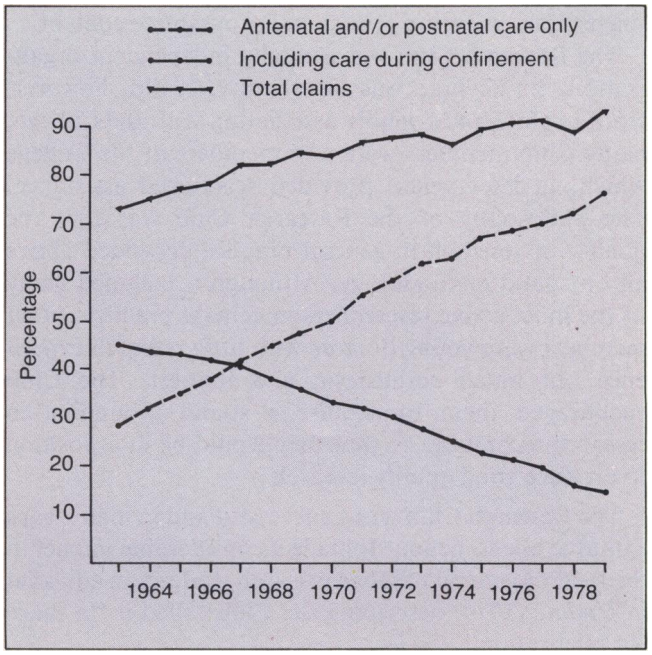

Table 1. Claims for maternity medical services (FP 24): England and Wales.

Year	Total births	Claims including delivery	Percentage	Antenatal and postnatal care claims only	Percentage	Total births claimed for (percentage)
1963	863,044	388,891	*44.8*	250,122	*28.8*	*73.6*
1964	890,518	386,575	*43.4*	286,179	*32.1*	*75.5*
1965	876,566	372,399	*42.5*	307,552	*35.1*	*77.6*
1966	863,066	352,447	*40.8*	322,070	*37.3*	*78.1*
1967	844,692	339,031	*40.1*	347,778	*41.2*	*81.3*
1968	831,120	309,378	*37.2*	368,232	*44.3*	*81.5*
1969	808,192	290,640	*36.0*	386,692	*47.8*	*83.8*
1970	794,831	259,349	*32.6*	396,321	*49.9*	*82.5*
1971	793,054	248,730	*31.4*	436,685	*55.1*	*86.5*
1972	734,376	216,973	*29.6*	426,751	*58.1*	*87.7*
1973	684,064	184,503	*27.0*	419,566	*61.3*	*88.3*
1974	647,100	156,952	*24.3*	403,445	*62.4*	*86.7*
1975	609,700	134,408	*22.0*	411,837	*67.5*	*89.5*
1976	586,200	124,077	*21.2*	402,445	*68.7*	*89.9*
1977	574,723	111,752	*19.4*	402,054	*70.0*	*89.4*
1978	601,573	98,831	*16.4*	428,472	*71.2*	*87.7*
1979	642,200*	98,694	*15.4*	483,420	*75.3*	*90.7*

*Provisional.

Table 2. Maternity medical services—1979. An analysis of FP 24 claims from six family practitioner committee areas.

	Oxfordshire	Newcastle	Northumberland	Staffordshire	North Tyneside	South Tyneside	Total
Total number of claims	4,936	3,379	3,983	13,922	2,376	2,030	30,626
Number of doctors claiming	211	123	147	484	100	64	1,129
Average number of cases per doctor per annum	23.5	27.5	27.1	28.8	23.8	31.7	27.1
Number of claims including care during delivery	1,667	210	870	2,346	317	129	5,539
Claims including delivery (percentage)	*33.7*	*6.2*	*21.8*	*16.9*	*13.3*	*6.4*	*18.1*
Number of doctors claiming care including delivery	128	23	64	333	48	16	612
Average number of deliveries per doctor per annum	13.0	9.1	13.6	7.1	6.6	8.1	9.1
Total doctors on family practitioner committee lists	361	214	283	771	183	136	1,948
Numbers on obstetric lists	308	160	220	699	148	111	1,646
Doctors on obstetric lists (percentage)	*85.0*	*74.8*	*77.7*	*90.7*	*80.9*	*81.6*	*84.5*
Doctors undertaking confinements (percentage)	*35.5*	*10.8*	*22.6*	*43.2*	*26.2*	*11.8*	*31.4*

country as a whole and indeed show very substantial variations which bear little relation to the number of doctors on obstetric lists. Clearly, in more rural areas (which presumably have a higher provision of general practitioner maternity units) a greater proportion of doctors undertake responsibility for deliveries. Nationally, however, it seems that less than one in three practitioners are so involved and their annual average case load is less than 10 patients per annum. The implications of such minimal continuing experience influenced our deliberations considerably.

Delivery at home, a topic of sometimes heated public debate, is not a numerically significant general practice activity at the moment.'

Lastly, the General Medical Services Committee (1980) has drawn attention recently to a new problem, namely, that with recent changes in basic medical education, general practitioners may not be adequately trained to provide emergency care for a pregnant patient, and so may be unable to fulfil their terms and conditions of service. The General Medical Council (1980a) has questioned this assertion.

The general position, therefore, is that at present there are three groups of general practitioners:

1. Those who provide shared antenatal and postnatal care in association with specialists.
2. Those who provide complete maternity services in-

cluding intranatal care.

3. Those who provide no obstetric care. The proportion probably varies substantially from one family practitioner committee area to another.

An unresolved question

We believe this summary of the present situation leads to two conclusions and raises a major question. The two conclusions are:

1. That every doctor on completion of basic medical education, whatever his future specialty, should be able to render immediate first-aid care in obstetric emergencies.

2. That intranatal care is not and need not be an essential component of general practice, but rather is an optional service which some doctors may wish to offer their patients.

The question, originally posed by the first RCGP Obstetric Working Party and as yet unanswered, is whether every general practitioner on completion of vocational training should be able to offer competent antenatal and postnatal care, or whether this service too should be optional, a matter of the practitioner's personal choice.

If competent antenatal and postnatal care is considered an essential component of general practice then there are implications for training, assessment, the certification of experience and the approach to payment, which would differ significantly if the service were to remain optional. Resolution of this question should therefore be seen as one important step in the profession's attempt to clarify the role of the future general practitioner in health care. By analogy, Council has recently debated another controversial component, namely, whether the health surveillance of children should be regarded as optional or essential.

The main arguments in favour of seeing antenatal and postnatal care as an essential part of general practice rest on the fact that, as pregnancy is an experience with profound physical, emotional and social dimensions, patients should not be deprived of the active involvement of their own general practitioner, who should provide continuing care for them and their families. The characteristics of general practitioner care that are of particular relevance in this context are as follows:

1. The doctor/patient relationship is already established at the onset of pregnancy and will continue after its completion.

2. The general practitioner is responsible for the overall care of the mother.

3. The practitioner is likely to be aware of the social background of the patient and actively concerned with the needs of the family.

4. The patient will tend to see only few doctors during the antenatal and postnatal period.

5. A relationship is already (or can during the pregnancy be) established with other members of the primary health care team (i.e. health visitor and midwife), who will later have responsibility for the continuing care of mother and baby.

6. The patient will receive her care in familiar and easily accessible surroundings which should facilitate her attendance.

We believe these reasons are compelling. We note that this view of the importance of antenatal and postnatal care in general practice was shared by the Charter Working Group of the General Medical Services Committee (1979).

Intranatal care

Although practitioners providing complete maternity services are in a minority, by reasons of geography and bed availability as well as professional choice, we believe that there is nevertheless considerable scope for an expanded general practitioner role in intranatal care. While the standards of care in some general practitioner maternity units are a cause for continuing concern, the high standards achieved in others provide examples of what can be done (Marsh, 1977; Steel, 1980). Similar considerations apply to domiciliary obstetrics. Moreover, we have been impressed by the extent to which general practitioners sharing beds with consultants in district general hospital units have been able to agree on a wide range of technical services to their patients, and at the same time have dispensed with many ground rules which have limited this activity in the past (Bull, 1980). Here is an opportunity for patients to have the best of both worlds; the evident benefits which flow from delivery in a unit capable of dealing with all unforeseen emergencies together with personal care from their own doctor.

Gynaecology today

Medical gynaecology has a well established place in the work of every general practitioner providing unrestricted general medical services. It is regarded as an essential component of general practice. Its importance has been enhanced recently with the recognition that general practice is the most important source of advice and management on family planning.

Education for obstetrics and gynaecology in general practice

In this section of our report we describe the educational implications which flow from the work of the general practitioner in this field.

Basic medical education

The General Medical Council (1980b), in its recommendations on basic medical education, says this about obstetrics:

> "The teaching should include instruction in the principles of human reproduction and family planning, and in the principles and practice of normal obstetrics. The teaching should emphasize antenatal and postnatal care, the management of normal labour and its complications, the impact of pregnancy on general disease and of general disease on pregnancy."

The recommendations also state that a young doctor, on achieving full registration, should be able to carry out simple practical clinical procedures and should be able to deal with common medical emergencies.

The College and the General Medical Services Committee have both received anecdotal statements that there may be a difference between what the General Medical Council recommends and what young doctors can actually do on completion of basic medical education. We suggest that the RCGP and the RCOG should together explore this question further, to see what evidence there is to substantiate the allegation and if there is such evidence to inform the General Medical Council.

We believe that, as a general rule, every young doctor achieving full registration should be able to demonstrate that he/she can provide effective first aid if unexpectedly faced with certain life-threatening emergencies in everyday life.

Vocational training

It is clear that for the foreseeable future the great majority of general practitioners will provide only antenatal and postnatal care. Some practitioners feel that a combination of basic medical education, day attachments to antenatal clinics, and experience in a teaching practice should enable trainees to acquire sufficient competence to furnish this limited service. We disagree. We believe that three months in an approved obstetric post is essential for these doctors because:

1. The young doctor needs to gain intensive experience of modern antenatal and postnatal care in its full context. Teaching practices cannot provide sufficient antenatal and postnatal cases in the maximum period of one year available to a trainee.
2. The young doctor must be able to relate antenatal and postnatal care to intranatal care. Intranatal care is almost wholly a hospital based activity.

It should be noted that the test we have applied, in determining whether or not hospital experience is essential, is the availability of suitable cases in general practice in sufficient number. Applying this test to other major clinical activities in general practice, we can think of none other where the case for hospital experience can be made so strongly. On the contrary, the application of this test to other subject areas demonstrates that hospital experience may be desirable, even highly desirable, but not essential.

The educational aims and goals for obstetric care should be prepared, published and reviewed from time to time by Council on the advice of its education committee. There should be full consultation with the Joint Committee on Postgraduate Training for General Practice, with the object of achieving common educational aims and goals if possible.

The arrangements for training will depend on whether antenatal and postnatal care is to be an optional or essential component of general practice. We compare the present (optional) situation with our recommendations in Table 3.

If the profession decides that the provision of antenatal and postnatal care should be an essential component, as we believe it should, a change in the Vocational Training Regulations would be required and an extensive remodelling of current obstetric posts would be necessary to provide the hospital experience. We understand from informal discussions with some obstetricians and gynaecologists that there is considerable scope for an increase in the number of hospital appointments giving three months each in obstetrics and gynaecology, but this matter would need to be considered further with the RCOG in the Joint Working Party. At the conclusion of vocational training, certification by the JCPTGP would indicate competence in the provision of antenatal and postnatal care on the basis of the assessments made by the specialist and general practitioner trainers. A further (elective) assessment should be incorporated in the MRCGP examination because the examination should assess the basic

Table 3. Antenatal and postnatal care.

Present situation	Our recommendations
Optional component of general practice	Essential component of general practice
Patients may obtain service from practitioners	Patients should expect service from their practitioners
NO AGREED EDUCATIONAL AIMS	Educational aims and goals recommended by RCGP and JCPTGP
Hospital experience optional	Three months' hospital experience essential
Vocational Training Regulations apply	Amendment to Vocational Training Regulations required
Assessment by DRCOG (elective)	Assessment by MRCGP (elective)
Assessment by consultant (required by obstetric list)	Assessment by consultant and trainer required
Local approval by Obstetric Committee	Certification by JCPTGP
Obstetric list operative	Obstetric list redundant

competencies of general practice. The need for the obstetric list would disappear.

If, on the other hand, antenatal and postnatal care is to remain optional, then a trainee could complete training without hospital obstetric experience, as the present Vocational Training Regulations allow. Doctors wishing to provide this service would require to have their obstetric experience specifically assessed and certificated, and thus the obstetric list would need to be retained.

We recommend that a doctor wishing to provide intranatal care, in addition to antenatal and postnatal care, should undertake a minimum of six months in an approved obstetric post. Assessment should be by the supervising specialist and the DRCOG examination (by election), since intranatal care would be an optional service.

Training for gynaecology and family planning

We have said that a consensus exists that medical gynaecology and family planning are essential components of general practice. Experience may be gained in the teaching practice, in hospital posts and in appropriate clinics.

When considering the training requirements of general practice in gynaecology it is important that the characteristics of such a programme should be clearly identified. The types of learning experience that will be needed can be considered under the following headings:

1. The acquisition of the basic knowledge and skills necessary to undertake the care of patients presenting with gynaecological problems.

2. Knowledge of hospital gynaecological practice so that the trainee is aware of the methods of investigation, range of diagnoses, and scope and forms of management that are currently practised.

3. Experience in those areas of gynaecological medicine, such as the functional disorders associated with menstruation and disordered sexual function, for which patient care within the general practice setting is particularly appropriate.

We believe that the teaching practice should become the central focus for acquiring such clinical experience because general practice generates sufficient cases. Further hospital experience is clearly desirable but cannot be regarded as essential.

Every vocational trainee should achieve the requirements for the Joint Certificate on Family Planning. We welcome the trend towards the appointment of more general practitioner teachers in family planning and we recommend that the counselling aspect of this work should be taught primarily in general practice, to both future general practitioners and to all other doctors who may wish to acquire the Joint Certificate.

The educational aims and goals for gynaecology and family planning should be prepared, published and reviewed from time to time by Council on the advice of its Education Committee. There should be full consultation with the Joint Committee on Postgraduate Training for General Practice, with the object of achieving common educational aims and goals if possible.

Approval of hospital posts

Joint visiting for the recognition of hospital posts in obstetrics and gynaecology by the two Colleges is now established. We believe that this initiative, especially when it is complemented by the selection of posts furnishing experience suitable for vocational training for general practice by regional postgraduate education committees, will lead to a better understanding of the educational needs of general practice and will be a force for change. This should enable trainees in hospital obstetric and gynaecological appointments better to meet their stated educational goals.

Joint visiting should also promote higher standards of care and of teaching in all junior hospital appointments, and should promote better relationships between the two disciplines.

The importance of continuing education and clinical audit

We stress the importance of keeping up to date, and of undertaking clinical auditing activities which enable performance to be monitored regularly. These activities should be encouraged on a voluntary basis, and should be regarded as something the good doctor will want and expect to do. They should provide the safeguard which patients have the right to expect.

We recommend that the regional subcommittees for general practice and obstetrics and gynaecology should together take a more active role in fostering effective continuing education.

Examinations

Since those components of obstetrics, gynaecology and family planning which are regarded as essential in general practice should have educational goals recommended by the education committee of Council, the relevant knowledge and skills of individual practitioners should be assessed by the MRCGP examination.

We hope that the RCOG will continue to offer its diploma in obstetrics and gynaecology. It will be especially important if antenatal and postnatal care continue to be optional components of general practice, and will continue to be the normal assessment of general practitioners who wish to provide intranatal care.

We recommend that the two Royal Colleges should collaborate more closely to try and ensure that the membership and diploma examinations have complementary rather than overlapping functions.

The obstetric list

If antenatal and postnatal care remains optional, the obstetric list will have to be retained. Should this be the case, we recommend that the regional postgraduate committees, particularly the education subcommittees for general practice, should become responsible for the maintenance and administration of the list. This would place the responsibility firmly in the hands of an educational authority recognized by the College and local medical committees.

We have said that if antenatal and postnatal care becomes an essential part of general practice, the trainee would be certificated by the Joint Committee for that service, and that for this purpose the obstetric list would become irrelevant.

Should this be the case, we suggest that the obstetric list should be dispensed with altogether. Doctors providing intranatal care are a minority and now undertake most of their work in general practitioner maternity units. They already enter into a contract with a local health authority, and it should be necessary only for that doctor to show the authority that he has gained the required experience satisfactorily in an approved obstetric post in order to practise. Those doctors wishing to undertake confinements at home could be certificated for the purpose by the regional general practice subcommittees if not already in contract with an authority.

Where such a doctor's work falls consistently below the standard set by his peers, the remedy would be to terminate his contract with the hospital authority, an option which exists already but is rarely used. By the same token, a practitioner undertaking home confinements unsatisfactorily should have his recognition withdrawn by the regional education committee for general practice.

The precedent for contract review has already been set by the RCGP and GMSC. The fitness of general practitioners to be trainers is reconsidered by regional postgraduate committees every five years or so. Hospital contracts could be negotiated on a similar, renewable basis.

Remuneration

We agree with the Charter Working Group of the GMSC that there should be only one level of fee for antenatal and postnatal care, and that this should reflect the higher standards of care we believe should be provided in future. If antenatal and postnatal care is optional, practitioners who have not been trained but who provide the service should receive no fees. Practitioners currently on an obstetric list would be regarded as trained.

The general practitioner undertaking complete maternity services is disadvantaged at the moment in that the fee for care during the confinement bears no relation to the time commitment or degree of responsibility required.

Our proposals should provide patients with a guarantee of higher minimum standards, and should promote standards of excellence. We suggest that the GMSC be asked to negotiate a fee structure which would properly reflect the standards being offered, and so act as an incentive to better obstetric care in general practice.

Obstetric care lends itself particularly well to the fee for item of service approach, and in this subject items of service can be closely related to performance.

Recommendations

1. The profession should decide whether antenatal and postnatal care is an essential or optional component of general practice.

2. All aspects of education for antenatal and postnatal care should be geared to reflect the decision on the type of service we say we are prepared to provide.

3. A young doctor, on completing basic medical education, should be able to provide first-aid management in obstetric and gynaecological emergencies.

4. All doctors undertaking intranatal care should first have completed six months in an approved obstetric post.

5. Every doctor completing vocational training should be eligible for the Joint Certificate on Contraception.

6. The RCGP and RCOG should collaborate more closely so that the membership and diploma examinations have complementary functions.

7. Regional postgraduate medical committees should take a more active part in determining the local educational arrangements for obstetrics and gynaecology for general practice, and where appropriate should monitor standards.

8. If antenatal and postnatal care become essential components of general practice, the obstetric list should be abolished.

9. Higher standards of care should attract higher levels of remuneration.

Members of the Working Party

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Pharmacy closures

The table below shows the number of pharmacies at 31 December from 1955 to 1979.

Year	Number of pharmacies	Net reduction in year	Percentage decrease
1955	15,302	11	0.07
1956	15,273	29	0.2
1957	15,192	81	0.5
1958	15,067	125	0.8
1959	14,953	114	0.8
1960	14,860	93	0.6
1961	14,750	110	0.7
1962	14,620	130	0.9
1963	14,509	111	0.8
1964	14,354	155	1.1
1965	14,137	217	1.5
1966	13,881	256	1.8
1967	13,618	263	1.9
1968	13,329	289	2.1
1969	12,851	478	3.6
1970	12,481	370	2.9
1971	12,202	279	2.2
1972	11,924	278	2.3
1973	11,673	251	2.1
1974	11,450	223	1.9
1975	11,162	288	2.5
1976	10,947	215	1.9
1977*	10,797	138	1.3
1978	10,701	96	0.9
1979	10,656	45	0.4

*Computerization of the Society's records in 1977 disclosed a discrepancy in the figures kept manually until then. Since this did not become apparent until 1979, the annual survey for 1977 (*Pharmaceutical Journal,* 1 April 1978, p. 276) is incorrect. The total number of pharmacies given above for 1977 is the correct one.

Source: *Pharmaceutical Journal* (1980). Survey of pharmacy closures, 1979. **224**, 712.