Opinions of general practitioners in Nottinghamshire about provision of intrapartum care

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Abstract

***Objective*—To examine the beliefs of general practitioners concerning intrapartum care.**

***Design*—Postal questionnaire survey.**

***Subjects*—All general practitioners with patients in Nottinghamshire Family Health Services Authority in September 1993.**

***Main outcome measures*—General practitioners' current involvement in maternity care, and beliefs on intrapartum care.**

***Results*—Of 694 general practitioners sent questionnaires, 550 (79·2%) replied. 529 of these were on the obstetric list; 437 had not attended a delivery in the past 12 months; 36 had attended two or more; 358 general practitioners did not wish to provide more intrapartum care; 349 did not feel competent to do so. Reasons for not wanting to provide intrapartum care included current workload (453), disruption to personal life (407), and the fear of litigation (377). General practitioners who already booked women for home delivery were more likely to wish to do more deliveries (62/42 *v* 61/316, $\chi^2=85{\cdot}3$; $P<0{\cdot}0001$) and to have more positive attitudes towards increasing women's choice in maternity care (90/22 *v* 195/151, $\chi^2=227$; $P<0{\cdot}0001$).**

***Conclusions*—The involvement of general practitioners in intrapartum care in Nottinghamshire is low, and most general practitioners are unwilling to increase their role. However, general practitioners who already book for home delivery are keen to do more.**

Introduction

Until the middle of this century intrapartum care was considered a fundamental part of general practice.[1] The situation has changed greatly, however, over the past 50 years, most women in Britain now giving birth in hospital. The move to hospital has occurred because of arguments that the safety of mother and child is better assured under specialist care,[1-4] but there is opposition from groups of women and members of the medical profession who argue that general practitioner obstetrics is as safe, if not safer, for women with low risk pregnancies.[5-9]

The Winterton report of 1992[10] and the Cumberlege report of 1993[11] advocated an emphasis on community based maternity care and increased choice for women concerning maternity care. These reports have suggested there may be an increased role for general practitioners in providing intrapartum care, particularly at home and in general practitioner units. I conducted a study to discover the maternity services provided by general practitioners around Nottinghamshire and their views on the new initiatives from government.

TABLE I—*Characteristics of general practitioners responding to questionnaire on intrapartum care*

	No of responders (n=550)
Male/female	406/140
On obstetric list	529
Provide antenatal care	528
Provide postnatal care	528
Book for home delivery	128
Postgraduate qualification:	
DRCOG	218
MRCOG	8
MRCGP	237
Hospital obstetric or gynaecology experience at senior house officer grade or above:	
None	69
6 Months	225
12 Months	169
⩾13 Months	40
No of deliveries attended in past 12 months:	
None	437
1-2	70
3-9	18
⩾10	18

Not all respondents answered every question.

Subjects and methods

I obtained the names and addresses of all general practitioners who had patients in the Nottinghamshire Family Health Services Authority and sent them a confidential questionnaire in the autumn of 1993. The questions covered their age, sex, number of children, medical experience and qualifications, membership of the obstetric list, whether they provided antenatal or postnatal care, whether they booked for home delivery, and how many deliveries they had attended in the past 12 months. General practitioners' views on 24 statements concerning intrapartum care were assessed by using a seven point Likert scale with a central "no opinion" box. Eleven of these statements were derived directly from the recommendations of the Winterton report and three from the recommendations of the Cumberlege report.

The returned questionnaires were analysed with the SPSS-PC statistical analysis package. Analysis of subgroups was done with a standard χ^2 test. Because of the number of comparisons being made significance was set at 1%, and only subgroups with more than seven significant comparisons are reported here.

Results

Of the 694 general practitioners in the sample, 550 (79·2%) responded. Table I shows the characteristics of these responders. Table II shows the responses to the 24 statements relating to provision of intrapartum care. Opinions did not differ significantly between men and women nor with degree of obstetric experience.

The 128 general practitioners who reported booking women for home delivery showed a difference of opinion from the other general practitioners on over half the statements. General practitioners who booked home deliveries were over three times more likely to agree that they would like to offer more intrapartum

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TABLE II—*Responses of 550 general practitioners to 24 statements concerning provision of intrapartum care*

Statement	No (%) of general practitioners		
	Agree	No opinion	Disagree
Ideally, I would like to be able to offer more intrapartum care to my patients	124 (23)	61 (11)	358 (66)
I believe that I am sufficiently competent in obstetrics to be able to offer intrapartum care to my patients	153 (28)	42 (8)	349 (64)
I am discouraged from offering intrapartum care by:			
My lack of confidence	267 (49)	62 (11)	217 (40)
Lack of hospital based general practitioner obstetric facilities	182 (33)	115 (21)	247 (45)
Fear of litigation	377 (69)	61 (11)	107 (20)
Rate of remuneration for intrapartum care	210 (39)	157 (29)	178 (33)
Disruption of my personal life	407 (75)	46 (8)	93 (17)
Attitudes of my fellow partners	203 (37)	109 (20)	178 (33)
My current workload	453 (83)	34 (6)	59 (11)
Women with uncomplicated pregnancy should be able to book with a midwife as the lead professional for all their maternity care	248 (46)	62 (11)	234 (43)
Obstetricians should be used primarily to provide expertise for those women who have complicated pregnancies	423 (78)	33 (6)	89 (16)
Vocational training for general practitioners in obstetrics needs to be radically altered	197 (36)	197 (36)	150 (28)
Women should be able to choose where they would like their baby to be born	286 (52)	86 (16)	173 (32)
The policy of encouraging all women to give birth in hospital cannot be justified on the grounds of safety	189 (35)	48 (9)	307 (56)
There is widespread demand among women for greater choice in the type of maternity care they receive	315 (58)	80 (15)	152 (28)
There is potential for a damaging demarcation dispute between the professional groups over how labour should be supervised	377 (69)	109 (20)	60 (11)
Midwives should carry out the routine examination of apparently healthy newborn infants, provided they are well trained in the detection of congenital abnormalities and the subtle signs of impending illness	221 (41)	68 (12)	256 (47)
The item of service payments to general practitioners for maternity care, as presently operated, should be abandoned and redesigned	182 (33)	185 (34)	177 (33)
A new system of remuneration for general practitioners for maternity care should be heavily weighted towards rewarding those who provide intrapartum care	150 (27)	100 (18)	297 (54)
It is wrong to remove a woman from a general practitioner list solely because she wishes to have a home confinement or midwifery only care	384 (71)	67 (12)	92 (17)
A duty should be placed on general practitioners to have in place arrangements for women to have a home confinement	92 (17)	46 (9)	398 (74)
Most maternity care should be community based and near to the women's home	385 (71)	58 (11)	97 (18)
Those general practitioners who wish to provide care throughout pregnancy, labour, and the puerperium should be enabled to do so	501 (92)	34 (6)	12 (2)
Vocational obstetric training at senior house officer level should concentrate on the normal and those aspects of abnormality that can be dealt with by general practitioners	418 (76)	62 (11)	67 (12)

care to their patients (62/42 *v* 61/316, $\chi^2=85{\cdot}3$, df=2; $P<0{\cdot}0001$), were more likely to feel competent (80/38 *v* 73/311, $\chi^2=101{\cdot}2$, df=2; $P<0{\cdot}0001$), and were less likely to report lack of confidence (32/84 *v* 235/133, $\chi^2=48{\cdot}1$, df=2; $P<0{\cdot}0001$), fear of litigation (72/42 *v* 304/65, $\chi^2=18{\cdot}7$, df=2; $P<0{\cdot}0001$), disruption to their personal life (74/38 *v* 332/55, $\chi^2=25{\cdot}1$, df=2; $P<0{\cdot}0001$), attitudes of their fellow partners (35/55 *v* 168/122, $\chi^2=19{\cdot}42$, df=2; $P<0{\cdot}001$), or their current workload (93/28 *v* 359/31, $\chi^2=21{\cdot}2$, df=2; $P<0{\cdot}0001$) as discouraging them from offering more intrapartum care compared with other general practitioners. They were more likely to agree that women should be able to choose the place of birth (90/22 *v* 195/151, $\chi^2=22{\cdot}7$, df=2; $P<0{\cdot}0001$), to believe that a widespread demand for choice exists among women (87/23 *v* 227/129, $\chi^2=9{\cdot}1$, df=2; $P=0{\cdot}01$), and to agree that the policy of increasing hospitalisation cannot be justified on the grounds of safety (68/52 *v* 121/255, $\chi^2=24{\cdot}8$, df=2; $P<0{\cdot}0001$).

Discussion

The degree to which the population of general practitioners studied in this survey are representative of general practitioners nationally cannot easily be determined. However, the descriptive statistics show broad agreement with figures produced for the BMA in 1993 on the number of general practitioners providing antenatal and postnatal care, the proportion of men and women, and the size of partnerships.[12] In the BMA survey, the proportion of general practitioners wishing to provide intrapartum care was 27·3%, which is in keeping with the 22·8% in this survey. However, the proportion of doctors providing intrapartum care was much lower than the 25% reported by Marsh *et al* in the Northern region in 1983.[13]

REASONS FOR NOT PROVIDING INTRAPARTUM CARE

The most important reasons given for being discouraged from providing intrapartum care were current workload, disruption to personal life, and fear of litigation. The workload of general practitioners has increased since the introduction of the new general practitioner contract.[14,15] Disruption to personal life has also been cited as justification for not continuing with obstetric work in America.[16] Although obstetric work in Britain does not necessarily take more hours, it does affect lifestyle. It could be difficult to persuade doctors who have given up obstetrics to take it up again if their lives are now less stressful.[17]

Litigation has been rising in all areas of medicine in recent years. Younger general practitioners seem to fear litigation the most. This may be because they are better informed of the risks, or because, as some commentators have suggested,[18-20] they have been in a hospital obstetric environment more recently and are more likely to have been "reared on a diet of abnormality and fear."[20]

Surprisingly, general practitioners did not find lack of remuneration an important deterrent. Increasing payments in line with the disruption caused by provision of intrapartum care has been suggested to be the best way of increasing general practitioners' participation,[21-23] but my results indicate that this may not be effective.

Training, too, was not considered particularly important. Smith's survey of general practice trainees found that though an obstetric senior house officer job increased perceived competence to perform obstetric procedures, it did not encourage trainees to use their skills.[24] It has been suggested that hospital obstetric training should be given only to those trainees who wish to provide intrapartum care.[23,24] General practitioners in this survey agreed that training should concentrate on normal deliveries and that obstetricians should primarily be used for the care of women with complications. Such an arrangement might therefore be welcomed.

MEETING DEMAND FOR CHOICE

The Winterton report concluded that most women have no choice about their maternity care. The Cumberlege report recommended that maternity services should be woman centred. Since most general practitioners in this survey did not want to offer intrapartum care it may be difficult to meet the increasing demand for more choice.

Practice implications

- The contribution of general practitioners to intrapartum care has dropped over the past 50 years to almost zero
- Two government reports have recommended that this trend should be reversed
- In this study most general practitioners were unwilling to increase their involvement in intrapartum care
- Reluctance was due to fear of litigation, current workload, disruption to personal life, and perceived lack of competence
- Attempt to increase general practitioner intrapartum care should concentrate on the minority of general practitioners who are enthusiastic about home delivery

A minority of general practitioners did wish to provide more intrapartum care and had positive attitudes towards community obstetrics, and these general practitioners were likely to book for home delivery already. Establishing local forums for enthusiastic general practitioners similar to those already run by the Association for Community Based Maternity Care would enable these general practitioners to identify ways of providing intrapartum care without unduly disrupting their personal life or their surgery time while at the same time reducing the likelihood of litigation.

Subspecialisation within general practice has become more common, larger partnerships using the skills of individuals in certain areas such as dermatology, cardiology, and ophthalmology for all patients.[25] Such arrangements could be applied to the provision of intrapartum care. Indeed, in some practices this is already happening. The experience in the Netherlands shows that the success of such an arrangement depends on the support of other professional groups, most importantly the obstetricians and midwives who currently provide most intrapartum care.[26]

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AN INCIDENT THAT INFLUENCED MY LIFE

Hope after eclipse and despair

"No hope," said that old ophthalmologist. A cold sweat trickled down my cheeks as he went on, "You know, my boy, once the retina is damaged by sunlght it's finished. After all, what would you expect if a piece of paper is pierced with a burning cigarette? The retina is in no way different."

I was 17, just two days before I started my first day as a medical student, when a disaster befell my life and proved to have far reaching effects on my medical career. It was one of the late summer days of 1968 when there was a total eclipse of the sun. Ignorant of the dangers of exposure to the sun I looked through a carbon smoked glass at the eclipse for 15 minutes with seemingly no immediate effects. That night, however, I noticed to my horror that the stars began to go out of sight when I looked at them directly, only to reappear when I looked slightly away. Next morning faces looked hazy and distorted, straight lines seemed bent and wavy, and small objects vanished altogether.

It was not difficult for my ophthalmologist to diagnose my condition as solar retinopathy caused by exposure of the retinal photoreceptors to the thermal effect of the solar infrared rays. His way of breaking the bad news and giving his prognosis, however, had nearly devastated my life. I went out with a feeling of despair, fretting about a future with no hope, no sight, and no career.

The course of my disease was far from that predicted. Within a few weeks the central scotomas became smaller and fainter with less and less visual distortion until after six months I regained my full sight and the glittering stars vanished no more. I eventually got my medical degree and went on to specialise in ophthalmology.

I have learnt important lessons from that incident which were consolidated by the gradually accumulated medical experience. I came to know that diseases rarely behave in a black and white pattern; there are many possible outcomes. Outright hopelessness can hardly be justified. Dogmas and absolutism should rarely have a place in medical thinking. I have also learnt the fallacy of comparing living tissues with all their potentials of repair and healing with lifeless and inert materials like a piece of paper.

Since that incident my approach to patients has been to keep hope alive in their hearts for if it were not for hope the heart would break. And to anyone who is tempted to watch the eclipse of the sun my advice is to sit in the comfort of their home and watch it on television.—ADNAN HASHIM *is an associate specialist in ophthalmology in Surrey*