MEDICAL PRACTICE

General Practice Observed

Changing pattern in a general practitioner obstetric unit

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Summary and conclusions

Over the past nine years in Watford the proportion of hospital confinements has increased and domiciliary confinements have almost ceased. The proportion of patients originally booked into the general practitioner obstetric unit and subsequently transferred to the consultant unit has increased. Most patients are transferred during pregnancy, and the numbers transferred in labour are decreasing. The proportion of GPs attending their patients for delivery is low: local practitioners appear to be prepared for the consultant unit to supervise delivery with the practitioner co-operating in antenatal and postnatal care and family planning.

There seems little doubt that the success of GP units depends on the enthusiasm and interest of individual practitioners.

Introduction

In 1968 a new maternity unit was opened in Watford containing 101 obstetric beds and special care cots. Each year between 2000 and 2300 mothers have been delivered in the hospital.

Consultants, general practitioner obstetricians, and administrators established a general practitioner unit within the hospital. It was agreed that initially 12 lying-in beds should be booked for GP obstetricians, who would deliver their patients in the same labour ward as the consultant patients. The hospital midwifery staff supervised the patients of both GP obstetricians and consultants. A constitution was agreed, from which the following quotations are relevant:

"Primary responsibility for the patients' care will rest with the GP obstetrician who should have ready access to consultant opinion at all times. . . . The general practitioner beds and cots will be under the overall supervision of the consultant obstetricians and paediatricians. However, this supervision will be subject to the ethical principles governing relationships between GPs and consultants. . . . A GP obstetric committee will be established to determine the organisation and policy of the GP obstetrician unit. An agreed code of practice will be drawn up based on current practice in the specialist unit, the recommendations of the Standing Maternity and Midwifery Advisory Committee, and the recommendations of the Royal College of Obstetricians and Gynaecologists."

The unit has functioned smoothly and always with close co-operation between the GP obstetricians and the consultants (Mr D MacRae, who retired in 1972, and Mr S Scorer, who died in 1970).

Patients and methods

Domiciliary deliveries—In 1968 there were 788 domiciliary confinements (table I), representing 26·8% of all patients delivered within the hospital's catchment area. This proportion has progressively declined, and in 1976 there were only 31 domiciliary confinements (1·4% of all patients delivered). The decline of domiciliary midwifery is caused by the availability of hospital beds, the recommendations of the Peel Report, the wishes of the patient and her GP, and the possibility of planned early discharge. The perinatal death rate has progressively declined.[1]

Deliveries in the GP unit—In 1969 303 patients were delivered in the GP unit (table II), representing 14% of the deliveries in hospital. This percentage remained fairly constant until about 1973, since when the proportion has declined (see figure). The fall in the number of patients delivered in the GP unit coincided with the introduction of routine continuous fetal heart rate monitoring and the establishment of an epidural service.

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TABLE I—*Numbers of domiciliary births as proportion of all births in hospital catchment area*

	1968	1969	1970	1971	1972	1973	1974	1975	1976
No of domiciliary births	788	543	450	324	205	129	84	60	31
% of all births	26·8	19·5	15·4	11·3	7·5	5·1	2·8	2·1	1·4

TABLE II—*Numbers (%) of patients delivered in GP unit*

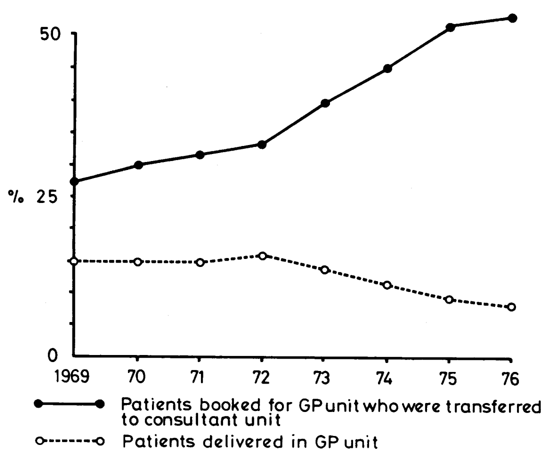
1969	1970	1971	1972	1973	1974	1975	1976
303 (14)	321 (15)	323 (15)	344 (16)	290 (14)	257 (12)	199 (9·5)	188 (9)

Transfers from GP unit to consultant unit—In 1969 115 patients, representing 27·5% of the patients originally booked in the GP unit, were transferred to the consultant unit (table III). This number has increased progressively, the rate of increase rising sharply from 1972 (figure). Over half of the patients now booked for delivery in the GP unit are transferred to the consultant unit. An analysis of the time in pregnancy during which patients were transferred from the GP unit to the consultant unit showed that the proportion of patients transferred in labour and the puerperium decreased (table IV). In 1976 over 70% of the patients were transferred during pregnancy; this reflects a greater awareness among GP obstetricians of pre-eclampsia, growth retardation, malpresentation, and other abnormalities.

Attendance of GP obstetrician during delivery—In 1970 the GP obstetrician attended at 34% of deliveries; this is the highest figure, and in 1975 the proportion was only 18% (table V). Although accurate figures are not available, a much higher proportion of patients were visited by the GP obstetrician at some time during labour or in the immediate puerperium.

TABLE III—*Numbers (%) of patients booked for GP unit who were transferred to consultant unit*

1969	1970	1971	1972	1973	1974	1975	1976
115 (27·5)	139(30·2)	150(31·7)	172(33·3)	189(39·5)	212(45·2)	214(51·8)	204 (52)



Deliveries in GP unit as percentage of deliveries in hospital and percentage of patients originally booked in GP unit who were transferred to consultant unit.

TABLE IV—*Percentages of GP unit patients transferred to consultant unit*

	1969	1970	1971	1972	1973	1974	1975	1976
During pregnancy	50·4	52·5	52·5	52·3	57·7	59·4	65·4	70·6
During labour	37·4	36·4	39·1	36·1	37·0	39·6	31·3	26·5
During puerperium	12·2	11·0	8·5	11·6	5·3	1·0	3·3	2·9

Discussion

What is the role of the GP obstetrician today? Marsh[2] considers that general practitioner obstetrics remains a desirable goal that could "improve the overall national statistics." He also considered that "when patient participation is becoming increasingly encouraged obstetrics above all specialties should be the one in which the mother's wishes and desires are met as well as the rather narrower clinical dictums of the obstetrician himself." Yet how can such an aim be achieved in the GP unit if over 50% of women choose to have an epidural anaesthetic when the choice is offered?

TABLE V—*Percentages of deliveries attended by GP obstetrician*

1969	1970	1971	1972	1973	1974	1975	1976	1977 (to May)
32·0	34·0	27·6	30·5	27·0	27·6	18·1	22·9	23·6

Statistics of perinatal deaths in GP units are not valid since most patients with obstetric problems will be transferred to the consultant. Richmond[3] showed that in 85% of cases where the baby died the patient was transferred to the consultant unit before delivery.

Is only the GP unit going to be responsible for normal deliveries? Richmond[3] suggests that operative interference by GP obstetricians may carry a higher complication rate than that seen in consultant units. Of 115 patients induced (mainly for postmaturity) in the GP unit, 22 (19%) were transferred for failed induction.

Furthermore, there may be a high incidence of patients transferred in labour to the consultant unit from the GP unit. James[4] reports that of 1150 patients delivered in a GP unit in 1975 201 (17·5%) were transferred, most for delay in the first and second stage of labour, fetal distress, and maternal hypertension.

There seems little doubt that the success of GP units depends greatly on the enthusiasm and interest of individual practitioners. Thus the good results reported by Marsh[2] and Richmond[3] represent the efforts of a committed group of practitioners. Yet even in this group enthusiasm for the supervision of labour itself would appear to be decreasing. Richmond[3] reported that the proportion of GP obstetricians present at delivery in six individual units varied between 19% and 47%.

The position is similar in our unit, where the proportion of GPs attending their patients for delivery is decreasing. More and more practitioners seem to be prepared to have the consultant unit deliver the patient, and to supervise the antenatal and postnatal periods and family planning themselves. Where adequate facilities for antenatal monitoring and epidural anaesthesia are available this appears to be a spontaneous decision of the GP obstetricians.

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References

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[2] Marsh, G N, *British Medical Journal*, 1977, **2**, 1004.
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