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## The G.P. Obstetrician - Gone For Ever?

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### Abstract

I never accept proffered cups of tea during the course of duty — well, hardly ever. The one invariable exception used to be the inevitable cup offered by the proud new father: his one constructive act at the time of the delivery at a home confinement. What could be more happy, more natural, more satisfying than the birth of a new baby in the environment of its parents' home, in the midst of the family to which it was the newest addition? When all went well — and that was undoubtedly the norm — the pleasure, indeed the unequivocal joy, of all concerned, parents, midwives, grannies, doctors — was one of the great abiding satisfactions of general practice.

There was, though, an obverse side to the coin. The prolonged labour with exhaustion starting to supervene, the occasional limp, apnoeic babe, the mother bleeding steadily with placenta stuck, these could cause concern and anxiety and sometimes downright alarm never fully compensated for even by the existence of the most efficient flying squad.

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# THE G.P. OBSTETRICIAN — GONE FOR EVER?

by

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## **The pattern of change**

Fifteen years ago when I started in practice we would have two or three home confinements a month — now we have none. What has happened, and why?

Somebody has said that the best place for a mother to have her baby was her own home and the best place for a baby to be born was in a hospital. There is much truth in that, if for 'in a hospital' one substitutes 'in easy reach of anaesthetists and paediatricians'. Obstetricians too,

perhaps, but not quite so urgently, for the skills of resuscitation, both paediatric and maternal, are required, if they are needed, within minutes, while obstetric skills can generally be deployed with slightly more leisure.

Childbirth remains (thank God) a physiological process, but neonatal mortality rates considered acceptable even a decade ago are now seen as an affront to proper care. Where human life is at stake risks have to be minimised. The recent advances in obstetrics have been largely in the field of monitoring and early intervention if indicated round the expected time of delivery. Technology has invaded the labour ward, and to be fair, so has humanity, in the sense that obstetric units now more than fifteen years ago, strive to be aware of and sensitive to the needs of mothers rather than laying down authoritarian and unquestionable regimes.

In the mid — 60's the g.p. obstetrician's first skill was in selection: the rigour of selection in many instances depended upon the availability of obstetric beds and the philosophy of local consultants. The grand multips and the women who had had a previous ante- or post-partum haemorrhage were obvious candidates for hospital confinement. But what about primiparity? The 'elderly primip' used to be 35, but the age at which consideration was given to this unlovely title steadily dropped.

What about previous instrumental delivery? With more and more primips being delivered in hospital and with an increase in the rate of intervention there were fewer para 1's who had not had inductions and/or forceps deliveries, and so

a cycle of hospital confinement — instrumental intervention — future hospital confinement was begun. Then there was the birth rate itself; the obstetric beds planned to accommodate the results of the post-war population 'bulge' were under less pressure as the birth rate stabilised, but they still needed to be filled.

Thus the criteria for possible selection for home confinement became more stringent till the point was reached where the g.p. obstetrician, often with experience as an SHO in obstetrics, and with a Diploma in Obstetrics, was attending only three or four confinements in a year. At this stage his intranatal skills were in danger of dis-use atrophy and if he was wise he withdrew from the field and reorientated his thinking, admitting gracefully that changed times required changed practices.

### **The present position**

The ideal solution, at least in urban areas, might seem to be the existence of g.p. maternity units, in close proximity to consultant units, with the facility of easy consultation and if necessary transfer of patients. To such a unit the patient, selected with proper consideration and given full antenatal care by her practitioner and midwife would be brought when in labour, delivered by the district midwife and the practitioner and, all being well, returned to her own home within four, twenty four, forty eight hours — whatever seemed appropriate in all the given circumstances.

Several such units exist south of the border and suggestions were raised that there might be similar units in Edinburgh, but these met with intractable opposition from the consultant obstetricians (for reasons not always very obvious) and from consultant paediatricians who had perhaps greater grounds for doubts about general practitioners' experience and skills in the more modern concepts of neonatal paediatrics.

Some general practitioners, especially in close geographical proximity, are able to deliver their own patients in consultant units (there is at present such a scheme in operation at the Simpson Memorial Maternity Pavilion in Edinburgh), and thus retain and practice their delivery skills. For the rest, does the virtual elimination of domiciliary confinements mean the demise of the g.p. obstetrician?

I think not — provided he sees his role as general practitioner first and obstetrician second. As a general practitioner his primary role lies in diagnosis and the establishment of relationships: diagnosis in the sense of the assessment of the physical, psychological and social well being of his patient rather than simply the attachment of pathological labels; relationships in the sense of building a pattern of continuity within which doubts and fears can be discussed and guidance given in as relaxed and informal a manner as can be established within any professional setting.

### **The pattern of care**

The modern g.p. obstetrician has the responsibility of confirming pregnancy, of arranging for confinement, of organising and supervising antenatal care, of overseeing the puerperium and of providing postnatal advice. Above all he has the responsibility of providing continuity of care.

In these days of population mobility a pregnancy is often the practitioner's first contact with a new family; it provides the opportunity for collecting data about the family and for getting to know at least the new mother-to-be and in many cases her earlier children who may come along to the antenatal clinic toddling or in push chairs and see the doctor in a non-threatening situation. The mechanics of antenatal care are not essentially different whether provided by general practitioner or hospital clinic, but the setting in general practice is likely to be more relaxed, less antiseptically clinical and almost certainly more personal.

The high technology of obstetrics — amniocentesis, ultrasound, foetal monitoring and so on — belongs properly to the hospitals; the simple technology of stethoscope and sphygmomanometer, trained hands and eyes and above all sensitivity to individual's needs belong wherever medicine and obstetrics are practiced well — in the community setting as much as in the institutional one.

The g.p. obstetrician must, as soon as pregnancy is confirmed, ensure that the benefits of high technology are made available to his patient; he must organise referral for booking for confinement and he must see that liaison is maintained between himself and the hospital so that the

fullest information is available should there be any sign that things are not progressing satisfactorily. Many of the base line measurements such as blood group, WR and MSU will be done at the hospital booking visit and there is little sense in duplicating these, but it is worthwhile for the general practitioner to take off blood for rubella antibodies at the earliest possible stage, as it is he who will have to sort out the situation if the mother comes in contact with a child with proven or suspected German measles.

### **Teamwork**

The organisation of the general practitioner's own antenatal clinic will vary depending on his supporting staff and availability of space. If it is possible to obtain the assistance of the local district midwives this is valuable not only because of the specialist skills they bring to bear but equally importantly to introduce the concept of teamwork and to enable midwife and mother to get to know each other before delivery, as increasingly district midwives are involved in puerperal care. Like general practitioners, district midwives (unless directly attached to hospitals, as many of them now are) have decreasing experience in intranatal work. With earlier discharge from hospital maternity units, however, the midwives' role in the home during the puerperium is of increasing importance as highly trained nurses and as experts in teaching the elements of baby care.

The other member of the primary care team who should be involved is the Health Visitor. Her role is an educational, preventive and supportive one, and she has a statutory duty to visit babies from the age of 10 days onwards. If she already knows and has established a relationship with the mother before the baby arrives on the scene then her effectiveness in her job at that crucial but emotional stage of the family's development is considerably enhanced.

The general practitioner in this as in many other situations acts as a co-ordinator of services, supplying some himself and enlisting the help of other members of the team as appropriate. The question of the 'leadership' of the team is one which is quite frequently debated, but in functional terms the debate tends to be unreal.

The ultimate responsibility rests with the general practitioner and while he need not be authoritarian his responsibility can only be discharged if he remains effectively in control as co-ordinator.

### **The new family**

Having provided at least the major part of the antenatal care the general practitioner will in present circumstances often (indeed in urban areas usually) hand over to the consultant obstetrician and his team the responsibility for care immediately before and after delivery and for the conduct of the delivery itself. However, obstetric care does not end with the delivery; it continues for some time thereafter before it merges imperceptibly into general medical care in the continuing process of advice on feeding, contraception, developmental assessment, immunisations and the management of illnesses in the family.

The visit or visits to the home of the mother and new baby after discharge from hospital provide an excellent opportunity to strengthen the link of the doctor-patient relationship which is the rock on which all good practice stands. Although this is the time when the midwife and the Health Visitor traditionally deploy their skills in giving detailed advice and help, the doctor continues to be the co-ordinator and it is he who must ultimately, with his colleagues, plan the policies which are to be followed with regard to follow-up and prevention (in particular developmental assessment and immunisation programmes).

The postnatal examination, traditionally at or about 6 weeks after delivery, provides an opportunity to demonstrate the role of the doctor and his team in preventive as well as curative medicine. Provision of, or guidance about contraception, advice on cervical smear programmes and perhaps breast self-examination, checking on rubella immunity status and emphasis on the importance of immunisations for the new baby are all important parts of this closing of a chapter which at the same time opens a new book.

### **Happy at his work**

Our practice midwifery bag is black and battered: it is a leather Gladstone bag and it bears in faded gilt letters the initials of my grandfather: it

was in use at my own birth and at the birth of one of my own children. Perhaps I can be forgiven a nostalgic pang as I glance at it gathering dust in a cupboard, ready still for use in an emergency, but not in regular action over the past eight or nine years.

Some of the fun and some of the romance has certainly gone out of the g.p. obstetrician's life with the handing over of intranatal obstetrics to the hospitals — but so too has some of the anxiety and the occasional tragedy. The g.p. obstetrician of today has an important role — the emphasis has

changed but the important core remains — that of establishing and maintaining a skilled caring relationship and providing stability and continuity. By remaining in the obstetric field (and there are provisions whereby he may opt out if he chooses to do so) the general practitioner can still lay claim to his other title of family doctor.

The march of time may have deprived me of those cups of tea, but it has not removed some of the deepest satisfactions of a challenging and satisfying discipline.



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