TALKING POINT

GP maternity units: implications of closure

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The voices of the protagonists for the closure of general-practitioner maternity units have been louder recently than the opponents.¹⁻³ If the former are successful then the implications for the patient, the profession, and the NHS will be grave. It is short-sighted to try and effect economies by closing small well-run units.

Patient

Decisions are often made in the NHS which take no account of freedom of choice for the patient. Not all patients are imbued with the idea of "machinery midwifery." Some still believe that pregnancy and labour are physiological events.

Delivery in a GP unit cements the doctor/patient relationship. This has often been built up over many years, with the midwife as well as with the general practitioner. This intangible factor is particularly important in obstetrics and is too often under-rated in medicine generally. One of my partners is a general-practitioner anaesthetist and patients have frequently told me of their fears in the anaesthetic room only to feel so much more relaxed when they discovered that the anaesthetist was their own family doctor. Despite the fact that attention has been drawn to the need for a good doctor/patient relationship, patients commonly complain of an impersonal approach in hospitals. They refer to the brevity of consultation, lack of information, and the disappointment at seeing different doctors at clinic attendances, comparing it unfavourably with the continuity of care given by GPs and the district midwife.

The general-practitioner maternity unit report for 1975 (John Radcliffe Hospital, Oxford) drew attention to the increase in domiciliary confinements over 1973 and 1974. While there were only 29 such confinements, 15 women had originally booked for the GP unit but had changed their minds about where they would like to have the baby. None of the infants had perinatal difficulties, though five of the mothers (17.2%) were nulliparous. The demand for home confinements may increase and is another reason why GPs should continue to work in maternity units. An indication of this demand is the Society to Support Home Confinements launched in 1974.

Profession

General-practitioner obstetricians are skilled and able practitioners who have met nationally agreed criteria for inclusion on the obstetric

list. They are able to supervise confinements in the context of an acceptable booking policy. They seek specialist opinion when the need for special skills arises either in the antenatal period or during or after labour. The closure of GP units would mean a loss of their skills and possibly much of the expertise of midwives in GP units. Justifiably, they are unlikely to accept withdrawal of this service to patients in the absence of any evidence that GP obstetrics is an inferior form of care.

SAFETY

Safety for mother and child is vital to the practitioner, be he consultant or GP. There are many statistics showing good midwifery practice by both consultant units and GPs. Nevertheless, these do not indicate the *relative* safety for patients booked under an acceptable policy for GP units compared with those booked under a consultant in a unit where there is no GP obstetrics practised. I regret that hospital statistics show only an overall perinatal mortality for cases ranging from "normal" to the most complicated deliveries. Our patients are entitled to a factual statement on the safety or otherwise of the type of care they will have in their confinement rather than an emotively expressed opinion. In the Oxford region, where there has generally been an accepted place for GP obstetrics in close liaison with the consultant service, the figures for maternal and perinatal morbidity

and mortality are outstandingly good (see table).

In some areas beds have been offered in a consultant unit in return for the closure of an urban GP maternity home. This has much to commend it, as full resources are available should complications arise during labour. It is a policy that has been favoured by many GPs for years but in most districts such access has not been made available. The consultative document on priorities⁴ forecast that the number of births will start to increase in 1977. This may result in insufficient numbers of beds in a few years time if present spare capacity in consultant units is taken up as an economy measure now. Unless the GP section of a hospital unit is clearly identified patients may not have their wishes met for a simpler type of maternity care.

TRAINEES

Trainee general practitioners generally see obstetrics only in their hospital training. The withdrawal of GP midwifery would adversely affect their training; they will not learn of an alternative form of care which can meet many patients' emotional and obstetric needs at much lower cost.

FALL IN LEAGUE TABLE

As the proportion of confinements under consultant care has increased since the Peel

Number of true maternal deaths, excluding abortion, and deaths from abortion only (in brackets) and maternal death rate per 100 000 live and still births, by hospital region in England and Wales, 1970-2*

Region	Reported true deaths	Unreported true deaths identified by OPCS	Total true maternal deaths	Live and† still births 1970-2	True maternal mortality rate (excl abortions) per 100 000 total births
Newcastle	17 (3)	2 (1)	19 (4)	144 455	13.2
Leeds	27 (7)	—	27 (7)	157 388	17.2
Sheffield	26 (6)	3 (—)	29 (6)	229 013	12.7
East Anglia	11 (1)	—	11 (1)	83 361	13.2
North-west Metropolitan ..	27 (15)	—	27 (15)	196 974	13.7
North-east Metropolitan ..	25 (9)	—	25 (10)	156 597	16.0
South-east Metropolitan ..	19 (5)	—	19 (5)	149 623	12.7
South-west Metropolitan ..	18 (5)	2 (1)	20 (6)	143 410	13.9
Wessex	6 (1)	3 (—)	9 (1)	93 124	9.7
Oxford	6 (2)	—	6 (2)	102 556	5.9
South-western	14 (6)	2 (—)	16 (6)	140 688	11.4
Wales	11 (7)	—	11 (7)	127 286	8.6
Birmingham	29 (4)	11 (1)	40 (5)	262 083	15.3
Manchester	26 (7)	2 (2)	28 (9)	222 927	12.6
Liverpool	12 (3)	1 (—)	13 (3)	112 014	11.6
England and Wales	274 (81)	26 (6)	300 (87)	2 322 124	12.9

*DHSS, *Report on Confidential Enquiries into Maternal Deaths in England and Wales, 1970-2*. London, HMSO, 1975.
†Regional figures exclude non-residents giving birth in England and Wales for 1972.

Report⁵ there has been some decline in perinatal mortality but the position of Great Britain in the European league has fallen.⁶ The case for total hospital confinement is not proven professionally.

Finance

The closure of isolated GP units is tempting because it neatly removes an identifiable expenditure in the present state of financial stringency. But will this constitute a long-term saving?

Hospital costing is so inadequate that in West Berkshire there are no figures that give even an approximate indication of the patient cost in the consultant obstetric department. The consultative document on priorities⁴ shows a rapid increase in expenditure between 1970 and 1973, despite a sharp decline in total births and a decreased length of stay in hospital (see figure). Is it supposed that "machinery midwifery" is financially economical or is it more likely that the rapid rise in cost

babies—one booked into a GP maternity unit in West Berkshire and the other into consultant obstetric units in control areas where there are no GP units. The study, which will cover around 2500 deliveries, has been divided into three phases. Firstly, a feasibility stage of three to six months, when expectant mothers are identified according to the recommended booking policy for inclusion in the survey; phase 2—a subsequent period of six months when those expectant mothers booked during phase 1 are delivered and further women identified for inclusion in the survey; and phase 3—a follow-up of the cases delivered in phase 2 and a review of the study to determine how long it will be necessary to continue in order to establish whether there is any marked difference between the two groups. The results should contribute to the continuing debate on the value of GP obstetric units.

Conclusion

In 1974 in one maternity home in West Berkshire threatened with closure there was a 77% bed occupancy—the highest for any of the GP units in West Berkshire and slightly higher than the consultant unit. The staff are expert midwives, many of whom have served

in the unit for several years, and staff morale is always high. The home is well appointed, having been modernised and extended to accommodate 25 patients in 1958-9, and could well expand its work to cope with the expected birth rate increase in Berkshire. Why shut down such viable units that are so appreciated by patients?

For reasons of patient choice, professional care and satisfaction, and economy I believe that there should be more GP units, not less. It is time that doctors united under the banner of "safety with simplicity" to produce an effective, economical maternity service.

References

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- ² Cox, C A, et al. *British Medical Journal*, 1976, **1**, 84.
- ³ Curzen, P, and Mountrose, Ursula, *British Medical Journal*, 1976, **2**, 1433.
- ⁴ DHSS, *Priorities for Health and Personal Social Services in England*. London, HMSO, 1976.
- ⁵ *Domiciliary Midwifery and Maternity Bed Needs*, Report of the Subcommittee of the Standing Maternity and Midwifery Advisory Committee of the Central Health Services Council. London, HMSO, 1970.
- ⁶ *British Medical Journal*, 1976, **2**, 1269.

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(1) Estimate based on type II maternity hospitals

(2) Some 80% of cases are births

(3) Including non-hospital births

Cost of hospital maternity medical services compared with total births, 1970-3.

Source: DHSS, *Priorities for Health and Personal Social Services in England*. London, HMSO, 1976.

per patient is directly associated with an increase in the proportion of hospital deliveries?

Maternity study

In 1974 the LMC Conference resolved that "In view of the possible changes in the provision of maternity services, this Conference recommends an assessment of complications and perinatal mortality in a comparable series of patients confined in consultant and general practitioner maternity units." West Berkshire Health District was selected for the study which aimed to compare the outcome of pregnancy and confinement using specified criteria in two similar groups of mothers and

General Medical Council: Disciplinary Committee

The Disciplinary Committee of the General Medical Council met from 7 to 16 March. Sir Robert Wright was in the chair. Eleven cases were heard and one case was adjourned until July 1977.

Erasure and suspensions

In March 1976 the committee directed that the registration of Dr John Rutland Dyson (Blackpool) should be suspended for 12 months following an inquiry into a charge against him relating to convictions for offences involving an abuse of alcohol. In March 1977 the committee considered a further charge against him relating to convictions for offences involving an abuse of alcohol and assault occasioning actual bodily harm. The committee directed that Dr Dyson's name should be erased from the *Register*. He was given 28 days in which to appeal. His suspension from the *Register* would continue until the erasure of his name is effected.

The case of Dr Sohrab Tehemuras Kamdin (Ormskirk) occupied five days. The committee judged Dr Kamdin to have been guilty of serious professional misconduct in that he had disregarded his personal responsibilities to his patients by failing personally to visit and treat certain named patients when requested to do so and their condition so required and by failing to make adequate arrangements for them to be treated; by improperly issuing a prescription to a patient without personally examining her and improperly delegating to a nurse, to whom he gave no adequate instructions, the diagnosis and treatment for that patient's illness; by improperly instructing a nurse on five or more other occasions to give injections to patients whom he had neither

seen nor examined; by cancelling or curtailing his surgery between 17 February and 30 August 1975, on 49 occasions without giving prior notice and without making adequate arrangements for treatment to be given to his patients attending and requiring medical attention. The committee directed the Registrar to suspend Dr Kamdin's registration for 12 months. Dr Kamdin was given 28 days in which to appeal.

In March 1976 Dr B Sandford-Hill's registration was suspended for a period of 12 months after an inquiry into a charge against him relating to convictions for offences of obtaining pecuniary advantage by deception and of carrying on the business of a company with intent to defraud. In March 1977 the committee directed that Dr Sandford-Hill's registration should be suspended for a further period of 12 months from 30 March 1977.

Other cases

Dr David Frederick O'Malley (Billingham-on-Tees) was found not guilty of serious professional misconduct. The committee directed the Registrar to restore to the *Register* the names of Dr Peter Fraser Haggart (St Albans) and Dr Sharangdhar Prasad (Birmingham). The cases of Dr David Arthur Kidd (Pontefract) and Dr Peter Millward Johnson (Edgware, Middlesex) were concluded. The committee admonished Dr Thomas Yellowlees Bennie (Bridge of Weir, Renfrewshire) as a result of his being convicted (after pleading guilty) on 50 charges of fraud, for which he had been fined £200. The committee decided not to restore Dr Hari Chand Khanna's name to the *Register*.