OBSTETRICS IN GENERAL PRACTICE

Home or Hospital ?

J. STALLWORTHY,* F.R.C.S., F.R.C.O.G.

A young primigravida was delivered at home of a healthy son by her general practitioner. He had many years' experience of domiciliary midwifery and in the neighbouring towns and villages the reward for all his hard work was an enviable reputation as a safe obstetrician. On this occasion, however, post-partum haemorrhage, more severe than he had hitherto encountered, caused him anxiety. When at last it was controlled the patient's general condition seemed surprisingly good, but as the placenta was retained he decided to send her to a large maternity hospital 20 miles away. It was mid-winter. In spite of the country being blanketed by snow the ambulance wasted no time on the journey, but when its doors were opened at the hospital the young mother was dead.

There is much to criticize in retrospect ; there usually is. This happened in 1938 and was the final tragedy leading to the establishment of one of the early Flying Squad services in England. The first call for help came from this same practitioner a few weeks after his first maternal death. After many years of safe midwifery he had two desperate confinements in rapid succession.

The important word "safe" requires further consideration. Because a doctor practises midwifery for a considerable time without a maternal death it does not follow that his accepted routine is safe. If it is not, tragedy is likely to come sooner or later for precisely the same reason that a driver who gains false confidence because he has never had an accident is killed when crossing the double white line.

Acceptance of the complacent attitude, "It has never happened to me," is responsible for much of the tragedy of life. Safety increases when the question, "Why has it never happened to me?" leads to self-criticism and the acceptance of necessary reforms.

Midwifery practice makes heavy demands on all involved. Unless a doctor is prepared to accept this fact, with its implications of hard work and high standards, he should not practise obstetrics. Any measure that increases the safety of the mother and baby inevitably decreases the strain on medical and nursing staff. An outstanding example is the increased confidence given to a general practitioner by the assurance that an efficient Flying Squad is available, even though the need to summon it may never arise. Doctors whose midwifery experience commenced before this service existed are quick to appreciate the difference. A team with better equipment and greater experience is available to accept responsibility in a crisis which could prove fatal.

This admittedly over-simplifies the position. In the first place the crisis is greater than many admit and is one of policy more than of clinical emergency, important though the latter is. Then there is the difficult problem of personal freedom with all its implications ; the right of a woman to choose where her baby will be born, and the right of a doctor to decide if he will accept responsibility for her care. His

decision may depend on where he is prepared to conduct the delivery. The driver whose licence is valid has freedom to drive. If, knowing that his tyres are worn, he is involved in a fatal accident the exercise of his freedom has brought disaster.

"Licence they mean when they cry Liberty ;
For who love that must first be wise and good"

was Milton's verdict on this issue.

An analysis of these two aspects of the problem, personal freedom and the crisis, may help achieve some sense of perspective in the case for and against home and hospital delivery.

Personal Freedom

The Patient

Before it is decided where a woman will be confined there are usually at least three people whose decision is important. They are the patient, the nurse, and the doctor. Any or all of these may be influenced by other interested parties such as relatives, friends, or even the local medical officer of health if home conditions are unsatisfactory. The patient has the right to express her choice, but it may be unwise or impossible to implement it. For example, a hospital short of maternity beds may refuse to admit her, provided she is physically and obstetrically normal, suitable for home delivery, and living in circumstances which make this reasonable. She may on the other hand want to have her baby at home when this could be dangerous, as for example after a caesarean section. In either case considerable persuasion may be necessary by both doctor and midwife before the patient will change her mind. The fact remains, however, that she has the final choice, and in exceptional circumstances the exercise of this has been an avoidable factor associated with maternal death. The doctor and midwife are the two people best equipped to so advise a patient on the possible implications of her choice that when it is made it will be wise. Occasionally their efforts will fail. The closer the harmony between midwife and doctor the greater the chance of success, and conversely disagreement between them can seriously affect the attitude of the patient and the choice she makes.

The Doctor

A doctor's first duty is to advise his patient. He has no authority to act until this is given to him, and even then he has the right to decide whether to accept final responsibility. The neurologist will diagnose a cerebral tumour but will not remove it, although almost certainly he will advise who should be invited to do so. The general practitioner will diagnose pregnancy in a woman with heart disease, epilepsy, or diabetes, but will not accept responsibility for her obstetric care. He may find that a patient is perfectly healthy and yet

* Consultant Obstetrician and Gynaecologist, United Oxford Hospitals.

refuse to conduct a domiciliary confinement. The right of choice is his. If he is convinced that he can care for her and her infant more safely in a maternity unit, he is fully justified in saying so. She may refuse to accept his decision, in which event if he remains firm she must find another doctor to deliver her at home. The implications of this, particularly with a young doctor establishing a practice, may cause him concern and even lead him to change his mind. If he handles the difficult situation tactfully and firmly, so that the patient realizes that his main interest is her welfare, an impasse is not likely to arise; but if it does arise, neither the doctor's reputation nor the prestige of medicine will suffer by his standing firm on the conditions under which he is prepared to practise.

The Midwife

When the midwife agrees with the doctor's attitude his task is made simpler; together, if necessary, they can educate public opinion. If her interest is in domiciliary midwifery, whereas his is not, his difficulties are increased. His greatest victory will be won when the nurse becomes his ally. This leads to consideration of the reasons why nurse or doctor prefer either domiciliary or institutional midwifery.

Location of Practitioner Units

In the first place the relationship between patient, nurse, and doctor is likely to be less personal in the hospital atmosphere than at home, but it need not be. Greater provision for both nurse and doctor to accompany patients into hospital and attend the confinement in a general-practitioner unit would do much to overcome existing differences between local authority and institutional midwives. With patients centralized in this way more efficient use could be made of available midwives. The early transfer home of normal patients would permit relatively few beds to make a major contribution to the maternity needs of an area. For this to be effective the practitioner unit must be sited in relation to community needs, and barriers inherent in the tripartite maternity service must be removed.

The present declared policy of having units associated with district general hospitals will meet an important local need in urban areas, but it must not be allowed to conceal the fact that a need exists in the villages and small towns where there is no general hospital. Many women in these areas will refuse to travel 20 miles (32 km.) or more to be delivered in a unit where it is probable their own doctor would be unable to attend for reasons of distance. The more midwifery a doctor does the higher the standard he should achieve but the less likely he would be able to continue his obstetric practice in an institution many miles away, and the less efficient would be his care if he did. His choice would therefore be to concentrate on domiciliary midwifery, in which he may not believe, or cease to work in a specialty in which he is both skilled and interested. Nor would this be all the picture. If small peripheral units are closed, or others as needed are not opened, there must be a considerable increase in domiciliary confinements, many more normal patients must be admitted to consultant departments, or general-practitioner units associated with district hospitals must of necessity become so big that their character will change. Problems of organization and control would become formidable and the advantages of a relatively small unit of 20–25 beds, or less, would be lost without compensating gains. General-practitioner units of 75–100 beds, which would certainly be necessary in some areas if the only accommodation of this type were to be provided in association with general hospitals, would produce so many problems that it is doubtful if they

could continue to function as efficient units of the type at present envisaged. Consideration of possible adaptations in staffing and control to make large units efficient is beyond the scope of this article.

Small and Large Units

The advantages and disadvantages of general-practitioner maternity accommodation are best described in relation to a small unit. From the viewpoint of many doctors the ideal would be just enough beds to meet the needs of their practice. This would provide an intimate and personal unit in which they would have personal responsibility for all that happened. Facilities for good work would be available at all times and would include sterile equipment, a safe and convenient bed or labour room table, efficient lighting, analgesic and anaesthetic apparatus, a resuscitation trolley, and other advantages often missing at a home confinement. The one-man unit, however, is uneconomic and lacks the advantages of working with colleagues and in this way sharing a wider experience. The major disadvantages of a larger unit are the lack of personal responsibility except for one's own patients, the dangers inherent in differing standards of care and differing techniques, with the difficulties this can cause to nursing staff, and personality problems, which tend to increase with the size of the unit. These can be accentuated, particularly with nurses, by variations in the standard of care and skill revealed by different practitioners. These difficulties are by no means insurmountable provided there is good will, pride in the unit, and a sympathetic understanding of mutual problems. An essential requirement is that the general practitioner must have had an adequate postgraduate training in practical obstetrics and maintain his interest and skill by constant practice. Six months as resident in an approved consultant unit provide a basic minimum of training, and responsibility for at least 50 patients a year is required to achieve the necessary experience and skill.

Organization of the Unit

Essentials to success are close and friendly liaison with a consultant department and the assurance that the general-practitioner obstetrician is an important part of the area obstetric service. A regular consultation clinic to which the practitioner brings problem patients is necessary to maintain that degree of contact with the consultant which is important to both. In spite of careful antenatal supervision emergencies will arise and the Flying Squad based on the consultant unit responsible for the clinics is the obvious choice for the necessary help. In this way a spirit of understanding and mutual respect is developed. If there is more than one general-practitioner unit in an area an occasional combined clinical conference organized by each in turn and attended by consultants and specialists in training provides a forum for the sharing of ideas and experiences. Finally, every unit, whether general practitioner or consultant, should analyse critically its work and produce an annual report. This provides a permanent record and a yardstick by which to measure future progress. Detail is unnecessary except in relation to failures such as maternal, foetal, or neonatal deaths. A summary of the year's work would include as a minimum the number of deliveries, stillbirths, neonatal deaths, inductions, forceps, abnormal deliveries, anaesthetics and the type used, requests for Flying Squad help and the reasons, and the number of patients transferred to the consultant department with the reasons for this and the outcome. The spirit of self criticism which has been encouraged by the Ministry of Health Confidential Enquiry into Maternal Deaths with such dramatic results can be fostered in this way to the benefit of the service.

It is significant that general-practitioner obstetricians who have access to maternity units of the type described tend to lose interest in domiciliary midwifery. None the less there must inevitably be a great many home confinements for the next few years, even if all women requested delivery in hospital. This provides a challenge to select most carefully those patients who can with least risk be delivered at home. The reports on Maternal and Perinatal Mortality emphasize the tragic consequences of attempting to provide obstetric care in the wrong environment. Common sense, knowledge, and obstetrical experience will facilitate wise selection.

The Crisis

It is useless to deny that this exists. On the one hand there is an increasing demand for hospital confinements which will increase progressively if the experience of other countries such as the United States, Canada, Australia, and New Zealand is a reliable guide. It almost certainly is. On the other hand, with a national figure in England and Wales of only 66% for institutional deliveries in 1962 there is already a shortage of maternity beds. Unless many more are provided in the immediate future the position will become worse with the expected continued rise in the number of births. The total in England and Wales rose from 2,079,275 in the three years 1952-4 to 2,140,376 in the following three years 1955-7, an increase of 61,101. The next three years (1958-60) produced

a dramatic rise of 181,853 to a total of 2,322,229. This was nearly three times the rate of increase in the previous years.

The policy crisis concerns where those mothers of 1964 and later years who request a hospital bed for their confinement will find one, and who will look after them if they do—and if they do not. The preceding articles in this series have for obvious reasons emphasized the abnormal aspects of obstetrics, but the fortunate fact remains that with adequate antenatal care most women can have normal confinements, satisfying to all concerned, provided the facilities exist and are used. These women do not need a consultant unit, staffed and equipped to deal with the abnormal and emergency problems of obstetrics. It is not only uneconomic to treat them there but in many cases it is psychologically wrong to do so. Those who wish to go to hospital need and seek the advantages of a home delivery combined with the safety of a hospital where the nurse and doctor who have cared for them during the antenatal period can be with them during the confinement. The place where this compromise exists is in a well-organized general-practitioner maternity unit. For the next few years it is certain that many women will prefer home confinement, and others will be forced to it because of shortage of hospital beds. The challenge to all engaged in obstetrics is to see that selection of patients for home delivery, general practitioner, or consultant care is wise at the first antenatal visit and is kept under constant review. The best results will be achieved by the most efficient teams in which general practitioners, midwives, and consultants will work in harmony.

TO-DAY'S DRUGS

Chlormethiazole

Chlormethiazole is marketed by Astra-Hewlett Ltd. under the name of Heminevrin.

Pharmacology and Chemistry

Vitamin B₁ (thiamine) given intravenously will sometimes produce a state of shock. The formula of thiamine (shown below) is made up to two distinct structures, one with the

features of pyrimidine and the other with those of thiazole, and it is the pyrimidine fraction which is responsible for the shock-producing effect. The thiazole fraction, on the other hand, has been shown to have sedating and anticonvulsant effects.

Heminevrin is the ethandisulphonate of 4-methyl-5-β-chlorethyl-thiazole, derived from the thiazole part of thiamine. It is claimed to be of very low toxicity.

Therapeutic Use

Heminevrin has been used mainly in the treatment of delirium tremens and other acute alcoholic states, and in condi-

tions such as mania associated with over-activity and agitation. There have been a few published reports on the use of heminevrin. These have all come from France and Sweden, and are rather unsatisfactory. No trials appear to have been carried out in the United Kingdom or the U.S.A.

During the early trials the drug was given intravenously, usually as a 2% infusion lasting several hours. Such a method is hardly likely to appeal to anyone who has had to deal with acutely disturbed patients. However, oral therapy is now recommended, and is claimed to be particularly useful in delirium tremens and in preventing alcoholic withdrawal symptoms. There is still insufficient evidence to assess the value of the drug by this method of administration. In spite of its relationship to vitamin B₁, heminevrin has no vitamin activity.

Dosage

Dosage depends upon the effect obtained after administering the drug, but in acute states 1 g. (2 tablets) can be given every 1-2 hours. The total amount given in 24 hours should not exceed 8 g. A special scheme is recommended for alcoholic patients. 18 g. are given over eight days in steadily decreasing doses. Tolerance may develop if treatment continues longer than one week.

Side-effects and Contraindications

The tablets have an unpleasant taste and should be swallowed whole. Side-effects include dyspepsia, nausea, and occasionally vomiting, dizziness, sneezing, and drowsiness. The drug should not be given in the presence of depression, and may precipitate depression in manic-depressive illness.