GP trainees' views on hospital obstetric vocational training

SIR,—The views of general practitioner trainees with regard to hospital obstetric vocational training, highlighted by Lindsay F P Smith, are of concern in relation to hospital training and the future provision of intrapartum care by general practitioners.¹

As part of an initiative to encourage intrapartum care by general practitioners a community obstetric support group has been formed. It recently completed a postal survey of 235 principals in general practice in the Southampton area, to which a response rate of 84% (198 replies) was obtained. Although 52% of the respondents had the diploma of the Royal College of Obstetricians and Gynaecologists or a higher qualification and 89% had completed a minimum of six months' hospital obstetric training, we found, as in Smith's study, that current provision of intrapartum care was not related to completion of the hospital training post or possession of the diploma. The training, however, had increased perceived competence in that, for example, those who had completed it and had the diploma were less likely to report lack of confidence as being a factor in dissuading them from providing intrapartum care ($\chi^2=4.96$, $p=0.03$). Thus I agree that hospital training in itself fails to encourage general practitioners to use obstetric skills, although, interestingly, we found that younger doctors were more likely to report that encouragement from senior hospital colleagues would increase their involvement in intrapartum care.

It would be naive, however, to think that simply altering the nature of hospital training, needed though such changes may be, would provide an answer. In our study the main factors preventing general practitioners from increasing their involvement in intrapartum care were that it conflicted with surgery hours, daytime workload, and onerous on call rotas and that it adversely affected their social lives. Among the most cited comments medicolegal considerations were prominent.

General practitioner obstetrics probably provides a safe, cost efficient way of delivering care in low risk pregnancies² with the advantage of personal knowledge of the expectant mother. Besides educational and other initiatives such as the organisation of local rotas of interested doctors and encouragement from hospital colleagues, it should be encouraged by the government and family health services authorities, which should allow for it in the hours of availability criteria in the general practice contract and provide remuneration commensurate with the disruption that it often entails.

A Z KADRI

St Peter's Surgery,
Woolston,
Southampton SO2 9AL

1 Smith LFP. GP trainees' views on hospital obstetric vocational training. *BMJ* 1991;303:1447-50. (7 December.)

2 Campbell R, Macfarlane A, Cavenagh S. Choice and chance in low risk maternity care. *BMJ* 1991;303:1487-8. (14 December.)

Doctors in the making

SIR,—*Doctors in the Making*,¹ which Stephen Hunter discusses in an editorial,² suggests formalising an arrangement that has tacitly been the case for some time. In reality experienced sisters have taken the lead in supporting and advising junior doctors for many years, but in many instances they have had to play the so called "doctor-nurse" game as their lines of authority have not been clear. It is important that this interrelationship has been acknowledged.

Furthermore, it is the sister who has day to

day responsibility for the smooth running of the ward. It is unrealistic to ask someone to manage an environment if he or she does not have some degree of authority for the people working there. Acknowledging lines of accountability would go some way to making this task less complex as well as giving recognition to the skill required of a sister.

The report offers a valuable insight into the work of junior doctors and suggests pragmatic solutions. It should be welcomed by nurses and doctors alike.

BARBARA VAUGHAN

Director, nursing developments programme,
King's Fund Centre for Health Services Development,
London NW1 7NF

1 Dowling S, Barrett S. *Doctors in the making. The experience of the pre-registration year*. Bristol: SAUS Publications, Bristol University, 1991.

2 Hunter S. *Doctors in the making*. *BMJ* 1991;303:1415-6. (7 December.)

Rugby injuries

SIR,—In response to the editorial and correspondence calling for an audit of rugby injuries^{1,2} I would remind doctors of the service provided by the consumer safety unit of the Department of Trade and Industry. The home accident surveillance system, leisure accident surveillance system, and home accident deaths database are all run by the department and can provide data in the form of tables or case listings. The data for the home accident surveillance system and leisure accident surveillance system are taken from a sample of hospitals in Great Britain selected to represent the population as a whole. Information on the injuries and circumstances in which they occurred are collected from the patient by interview and from the medical records. Data for the home accident deaths database are collected from the Office of Population, Censuses and Surveys and area electricity boards and from death registration forms.

Those concerned with rugby injuries may wish to know that in 1989 the leisure accident surveillance system recorded 2574 patients reporting to an accident and emergency unit with injuries sustained while playing rugby (a national estimate of 91 000). Further information (for example, type of injury, age of patient, length of inpatient stay) can be obtained from the consumer safety unit, Room 306, 10-18 Victoria Street, London SW1H 0NN (tel 071 215 3215). The unit can also supply an annual report on the three databases, containing the most requested breakdowns of data.

HELEN PEDLEY

Department of Trade and Industry,
London SW1H 0NN

1 Garraway WM, Macleod DAD, Sharp JCM. Rugby injuries. *BMJ* 1991;303:1082-3. (2 November.)

2 Correspondence. Rugby injuries. *BMJ* 1991;303:1401-2. (30 November.)

The health strategy

SIR,—David J Hunter is right to observe the need for intersectoral action at the central level of the Whitehall "village."¹ But this is only one of the levels at which policy can be formed, albeit an important one for matters such as tobacco taxation. He has failed to recognise the regional or sub-national level of activity that is of increasing importance both in the United Kingdom and throughout Europe.

The World Health Organisation's European regional office recently convened a meeting in Switzerland at which representatives from Lower Saxony, Catalonia, the canton of Geneva, Wales, and elsewhere came together to discuss the de-

velopment of subnational policies for health. The emphasis was on health, not health services, as the starting point in the analysis, and on local arrangements for participation in both the formulation of policy and the implementation of programmes. Wales has been following this approach since 1989² as it attempts to fold the principles of Health for All by 2000³ into the fabric of its health service. The Welsh protocols for investment in health gain are further evidence of a health focus, and each emphasises the need for intersectoral collaboration.^{4,7}

The fulcrum has been shifting for some time in many English regions and districts, and it is at these levels, rather than through central effort, that real differences will be made in terms of health status.

MORTON M WARNER

Welsh Health Planning Forum,
NHS in Wales,
Cardiff CF2 1DB

1 Hunter DJ. The health strategy and the hole at the centre. *BMJ* 1991;303:1350. (30 November.)

2 Welsh Health Planning Forum. *Strategic intent and direction for the NHS in Wales*. Cardiff: Welsh Office/NHS Directorate, 1989.

3 World Health Organisation Regional Office for Europe. *European regional strategy for attaining health for all*. Copenhagen: WHO, 1981.

4 Welsh Health Planning Forum. *Protocol for investment in health gain—cancers*. Cardiff: Welsh Office/NHS Directorate, 1990.

5 Welsh Health Planning Forum. *Protocol for investment in health gain—cardiovascular diseases*. Cardiff: Welsh Office/NHS Directorate, 1991.

6 Welsh Health Planning Forum. *Protocol for investment in health gain—maternal and early child health*. Cardiff: Welsh Office/NHS Directorate, 1991.

7 Welsh Health Planning Forum. *Protocol for investment in health gain—physical and sensory disability*. Cardiff: Welsh Office/NHS Directorate, 1991.

SIR,—David J Hunter's proposal in his editorial that government departments are incapable of transcending their inherent rivalry in order to collaborate is reasonable.¹ He warns that the Department of Health's consultation document *The Health of the Nation* may fail as a result. He suggests that the Department of the Environment should lead on health issues and advocates a new interdepartmental mechanism to broaden the health debate. He comments favourably on the recent developments in New Zealand whereby public health services have been separated from personal health services. This mixed bag of remedies is highly questionable.

Firstly, the Department of the Environment has shown no evidence hitherto of working outside its brief towards a broader health strategy. Leadership on environmental control policy has come recently from the European Commission. Secondly, Hunter offers no evidence that a new cross departmental mechanism will have more success than similarly ill fated initiatives (the Department of Economic Affairs and central policy review staff).² Thirdly, his recommendation of a managerial separation of personal and public health services needs greater description and justification.

Is he recommending the creation of a new government department with a network of regional public health services? Such an arrangement seems unlikely to advance the development of a coherent health strategy. The Department of Health has received an overwhelming response to its consultation document. The process has a considerable way to go. Another reorganisation of the health system can only add to the "change fatigue" being felt by those in the NHS currently trying to implement an imported organisational model. We wonder, like McLachlan, whether an obsession with structure, based on managerial theory, may be an obstacle to formulating broad based health policy.³

Or is Hunter suggesting that the separation of services should occur within an administrative unit responsible for a population similar to that of New Zealand (3.3m), such as an NHS region or Wales? The integration of a wide range of services for health at a regional level has attractions for the