There are at least 13 randomised controlled trials of assertive community treatment in the world literature, 12 of which have found the approach beneficial when compared with routine management. There are at least nine randomised controlled trials of standard case management and two well designed non-randomised controlled studies, all but one of which have largely negative findings. Curiously, the whole thrust of community care policy in Britain is towards the implementation of standard case management by another name.

Case management arrived in Britain in the late 1980s, giving rise to two parallel but closely related developments: social services "care management" and the health services "care programme approach." Social services care management was the first to take off, after the publication of the Griffiths report on community care.³ This report recommended that case management (provided by social services) should be at the heart of community care for severely mentally ill people. Griffiths had a particular eye on the brokerage aspect of case management, seeing it as an efficient means of providing "tailored" packages of care. After the Griffiths report a number of confusing and disruptive "innovations" ensued. In some areas social workers were withdrawn from clinical duties to act as "purchasers of care," plunging existing multidisciplinary teams into chaos.⁴ In other areas, social services "care management" teams were set up to provide clinical care in parallel with existing mental health services. Such evaluations of these teams as took place provided little evidence of efficacy, leaving social services care management in limbo.^{5,6}

Meanwhile the case management idea was being imposed on the mental health services in the form of the "care program approach." This was intended to run in tandem with care management, though how or why this should happen has

never been clarified. Originally the approach was reserved for the most severely ill patients, to whom the mental health services were required to appoint "key workers" (or case managers). The patients were to receive an assessment of need, a written care plan, and regular reviews organised by the key worker. It is possible to see how, with proper funding and guidance, this approach might have evolved into an approximation to assertive community treatment. In practice, the care programme approach has meant standard case management for all, through a combination of lack of funding, mushrooming paperwork, and its extension to all psychiatric patients. The care programme approach has never been fully evaluated, but a partial evaluation in a recent randomised controlled trial produced disturbing findings: a doubling of hospital admission rates for the care programme group.⁷

Case management, a practice with little justification, has displayed an astounding ability to flourish in the age of evidence based medicine. There is a simple explanation for case management's immunity to scientific analysis: in Britain it is no longer just an intervention, but a government policy.

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Antenatal care on trial

Pregnant women don't like minimalist packages

See pp 546, 554

There has been a growing worry among health professionals that much of antenatal care has become an unthinking ritual with few tangible returns and much inconvenience for pregnant women.¹ The scheduling of clinic visits was inherited from the 1920s, when the risks from pregnancy were quite different. Many believe that, today, we have too many antenatal visits to see too many different professionals in too many settings.

Several bodies have advocated possible improvements, including smaller "packages" of antenatal care (in which each visit has an explicit clinical purpose) and different mixes of contribution by general practitioners, midwives, and obstetricians. Obstetricians disagree as to whether they should, or should not, be involved in the antenatal care of healthy women with normal pregnancies.^{2,3}

There is, however, little quantitative evidence of high scientific quality to inform these debates. Randomised trials have assessed the effects of combined antenatal and intrapartum care by midwives and of domiciliary care for women with complications, but until now there have been only two randomised trials of different patterns specifically of antenatal care^{4,5}; both were small. Two additional and much larger trials are published in today's issue of the *BMJ*: the Scottish trial by Tucker *et al* (p 554) compares routine

antenatal care delivered by general practitioners and midwives with conventional "shared care" routinely involving specialist obstetricians,⁶ and the London trial by Sikorski *et al* (p 546) compares the traditional British antenatal schedule of visits with a reduced package.⁷ Both reports make important contributions to the debate.

Antenatal care of course aims to provide multidimensional benefits that include clinical improvements, education, and psychological and social support when required. Substantive adverse clinical outcomes are rare and neither trial is of sufficient size and power to draw important conclusions about the effects of innovative systems of antenatal care on clinical outcome. Interestingly, though, the Scottish trial found fewer women with proteinuric pre-eclampsia in the group cared for by general practitioners and midwives; it is important to establish whether this is due to chance, or decreased incidence, or failure of detection. The effects of fewer antenatal visits on important clinical outcomes may be illuminated by a completed but as yet unpublished trial from Zimbabwe.

The new trials also provide important information about the views of pregnant women on the studied innovations. In the London trial, women in the "fewer visits" group expressed significant dissatisfaction: they were more likely to

worry about their baby (both antenatally and postnatally), more likely to have negative views about their baby, and more likely to be dissatisfied by the number of antenatal visits they received. This finding is compatible with earlier observational data from Aberdeen which catalysed reassessment of antenatal care in Britain.⁸ In the Scottish trial, both groups expressed high and similar levels of satisfaction, but the groups made similar numbers of antenatal clinic visits.

In England and Wales, maternity units are investigating ways of implementing the Cumberlege report, *Changing Childbirth*, with its emphasis on woman centred care and continuity of caregiver.⁹ No one seriously believes the government's casual assumption that the changes can be implemented within existing budgets, and ongoing pilot schemes will evaluate the scale of increased expenditure. It has been assumed that some savings can be made by decreasing the number of antenatal visits. However, as the London trialists have shown, women may neither wish this nor indeed tolerate what they could interpret as trimming the service for financial expediency. On the other hand, current expectations are strongly influenced by past experience of antenatal care, and if this were to be packaged differently then expectations may change with time.

Whatever will evolve, it is essential that current arrangements are responsive to the current needs and expectations of pregnant women. It would be unfortunate if a genuine

attempt by professionals to improve the quality of antenatal care was seen instead by pregnant women as a complacent disregard for them and their babies. Some elements of change do seem acceptable, including packages of care that involve consultant obstetricians only when problems arise. However, the London trial should save the maternity services from making the mistake of implementing unpopular, infrequent timings for antenatal visits.

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Sustaining general practice

Re-engineering and a new charter are needed for the next millennium

See p 532

After 30 years of considerable achievement, the attractiveness of general practice as a career is again in question, and along with it the viability of primary care. The British government has placed great store on a primary care led health care system, but its rhetoric has not always been matched by clear consensus about development, concern for staff welfare, or adequate spending. There is widespread concern over job satisfaction, morale, autonomy, workload, bureaucracy, recruitment, and retention. A report from the BMA's General Medical Services Committee¹ adds to several recent reports²⁻⁴ in suggesting ways of restoring the sparkle to primary care.

The committee's report reviews statistics and trends in the existing medical workforce, the supply of doctors, and the changing pattern of work and demand. Although general practitioner numbers have been rising, and at about 31 000 are now at their highest level ever, this trend is threatened by a move towards earlier retirement, a rising proportion of part timers, an increasing proportion of women (whose pattern of lifetime work contribution is different to that of men), the effects of the 1985 restrictions on migration of doctors from outside the European Union, and a major decline in the number of community health doctors. The problem is exacerbated by the parallel expansion of the secondary medical care workforce, which must recruit from the same limited pool of medical graduates, and the inevitably long delays before any expansion of medical school intake will take effect. Meanwhile, general practitioners' workloads have increased because of transfers from secondary to primary care.

The report concludes with recommendations for limiting further expansion of general practitioners' workload; providing greater resources for additional support staff, better

premises, and technological help; and improving the supply of doctors and the ease of re-entry for those not currently practising. The report calls for adequate time for leisure and study and for flexible working arrangements to enable doctors to undertake a commitment appropriate to their personal circumstances.

The report contributes to the necessary debate about future patterns of medical practice in a rapidly changing society. However, it does not look at alternative ways of organising services, nor does it examine the opportunities that can result from using non-medical staff and emerging technology. While recognising that an increasing number of doctors are taking time out to practise overseas, pursue other interests, or spend time with their families, it does not explore the extent to which doctors may wish to enjoy a more varied "portfolio" career in the future and may need different types of contracts to enable them to do so. Forty years of commitment in the same practice in the same town, acquiring a house, a family, some holiday experiences, and perhaps a dog along the way, before a comfortable retirement, does not represent the total life aspirations of many of today's young doctors. Many of those who left Britain in earlier decades did not return, and quite apart from the morality of poaching doctors from poorer countries to replenish our stocks, there are increasing blocks to migration. We should seek to be largely self sufficient, even though some exchange of people, experience, and ideas is useful. Re-entry arrangements should be made as attractive as possible to reflect the vast capital investment of training a doctor.

What then is needed to take primary medical care into the next century? Firstly, we need to acknowledge that there are many different ways in which first class primary care can be