Training for overseas doctors may not be appropriate

EDITOR,—James Owen Drife highlights the inappropriateness of much medical work that takes place in the developing world.¹ Regrettably, Britain contributes much to this. Many of the doctors who attended the congress in India about which Drife writes will have received much of their medical training in Britain. How helpful was this training in addressing the real health needs (obstetric and others) in these doctors' own country? The curricula vitae of overseas doctors applying for positions in Britain often mention the doctors' desire for "specialty training." The attendance at the seminar on in vitro fertilisation in India reflects this attitude.

As long as we continue to train overseas doctors in Britain as if they were returning to situations similar to those in western Europe and as long as the royal colleges seem to pursue the same agenda, Drife's experiences will continue.

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1 Drife JO. We know why they die. *BMJ* 1996;312:1044. (20 April.)

GMSC's advice on intrapartum care

GMSC's advice differs from royal college's

EDITOR,—The maternity task group of the Royal College of General Practitioners recently published its report *The Role of General Practice in Maternity Care*.¹ Involvement in intrapartum care is a particular issue for general practitioners, and in its attempt to clarify the issue the report clearly differentiates between domiciliary intrapartum care and that which can be undertaken in an institutional setting.

At home the principal professional involved will always be the midwife. The role of the general practitioner is to ensure that his or her patient receives appropriate advice and care; it is not to provide specialist obstetric or neonatal care.

The General Medical Services Committee's recent report *Maternity Medical Services Legal Advice* takes a different standpoint and recommends that "practitioners who are going to provide intrapartum care should be the relatively few [general practitioners] who are highly skilled and practised in this area and that only they should undertake home deliveries and deliveries in [general practitioner] maternity units."² This raises important questions. What does the committee consider to be the role of the general practitioner in domiciliary care, and what skill does it expect him or her to have? If the committee expects the ability to undertake certain obstetric interventions then it can be strongly argued that, even if the general practitioner did possess such skills, it would be inappropriate for him or her to use them in the home setting.

The General Medical Services Committee's recommendations emanate from a legal opinion. The objective is clearly to minimise a perceived danger of litigation, which is very different from that of wishing to optimise the delivery of health care. Intentionally or not, this report will have far reaching implications for services and education by deterring practitioners from becoming involved in the intrapartum care of women requesting home births (particularly those general practitioners who at present provide this form of service). As a result, trainees will probably question the value of including obstetrics in their vocational training. This is the exact opposite of the view expressed in the report of

the Royal College of General Practitioners, which suggests that vocational training should ensure that general practitioners are prepared to provide total primary maternity care.

It is to be hoped that the different approaches contained in these two reports will stimulate a discourse between the Royal College of General Practitioners and the General Medical Services Committee for the benefit of both general practice and pregnant women.

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1 Royal College of General Practitioners. *The role of general practice in maternity care*. London: RCGP, 1995. (Occasional paper 72.)

2 General Medical Services Committee. *Maternity medical services legal advice*. London: GMSC, 1995.

Committee is out of touch with needs of profession

EDITOR,—As one of few local NHS general practitioners who provide patients with a comprehensive, personal 24 hour medical service I often feel isolated, vulnerable, and exposed to censure. I question the motives behind the General Medical Services Committee's recent advice about the provision of intrapartum care.¹ A G Baird and colleagues confirm the ability of most general practitioners to provide a satisfactory intrapartum obstetric service,² and, in accord with Jeremy Bradbrook and colleagues, I consider the committee's advice to be damaging.³

I recently received correspondence from the clinical director of my trust's maternity unit, who states that the trust considers any medical intervention during pregnancy to be the sole responsibility of hospital obstetricians. I was particularly concerned that this same manager also seems to believe in a planned "place of normal confinement" and considers that planned home deliveries under his nominal supervision are safe with the support of paramedics alone. Surely all general practitioners are qualified in midwifery; vocational training must equip them to manage most obstetric problems more adequately than any paramedic. If standards are as low as the General Medical Services Committee supposes then perhaps we should examine the educational content of current senior house officer posts in obstetrics and call for refresher courses to improve standards.

Bradbrook and colleagues overlook a major conflict of interest.³ When attending any patient, doctors still carry vicarious liability in common law for the acts and omissions of any midwife or ambulance paramedic working with them, although they have no managerial control since the midwife or paramedic is answerable firstly to his or her employing trust and works to various protocols dictated by the trust. These protocols may not correspond with the patient's wishes or needs or the doctor's professional judgment, and I find this to be a continuing source of conflict as the trusts have a powerful vested interest in generating a monopoly in the provision of services.

Intrapartum obstetrics is one of the most rewarding aspects of family medicine, but, like all aspects of immediate care, it requires skill and practice. Obstetrics also takes time and so cannot be provided by any deputising service or cooperative. I believe that the General Medical Services Committee's advice and its call for the removal of maternity care from general medical services have more to do with the drive towards corporate medical services and privatisation than with any hypothetical issues of negligence and

malpractice. Furthermore, they suggest that its members are out of touch with the needs of the profession.

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1 General Medical Services Committee. *Maternity medical services legal advice*. London: GMSC, 1995.

2 Baird AG, Jewell D, Walker JJ. Management of labour in an isolated rural maternity hospital. *BMJ* 1996;312:223-6. (27 January.)

3 Bradbrook J, Carmi M, Danby J, Fawdry R, Fletcher J, Gill D, et al. GMSC's advice on intrapartum care is unhelpful. *BMJ* 1996;312:910-1. (6 April.)

BMJ's embargo should not be broken

EDITOR,—We are writing to express our concern at the way the embargo arrangements were handled for the release of the information relating to the two papers on smoking and the sudden infant death syndrome in the *BMJ* last week.^{1 2} It was unfortunate, to say the least, that Fergus Walsh, the BBC's medical correspondent, was allowed to use this information on Wednesday evening, rather than on Friday morning as is normal.

We realise that coordinating the joint release of information between three parties—in this case the *BMJ*, the Department of Health, and the Foundation for the Study of Infant Deaths—can be problematic, but the system has worked perfectly satisfactorily in the past. Press conferences about articles in the *BMJ* (and *Lancet*) are often held on a Thursday for publication on Friday morning. In this case, even though the Department of Health and Foundation for the Study of Infant Deaths were unwilling for some reason to agree to this, the *BMJ* should have stuck to its own embargo. Because the *BMJ* said that it would take no action against the BBC, everyone was forced to break the embargo on Wednesday night.

This is not a matter of journalistic pique at being scooped by a rival. The embargo system allows the full data to be studied, the experts to be listened to and questioned, and adequate time and, hopefully, space to be devoted to the story. Scrambling a few paragraphs together at night when there is no time or space left in the newspaper serves no one well—not the researchers, not the doctors who will hear the news from patients, and certainly not the readers who could make use of such information.

The embargo system is fair to both the broadcast media and newspapers, yet in recent months it has been abused by the electronic media. If this continues to happen, a service that is of benefit to journalists, doctors, and the public will fail. The embargo system should be maintained. There is a simple sanction that can be taken against journalists who break it: do not send them information in future.

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1 Fleming PJ, Blair PS, Bacon C, Bensley D, Smith I, Taylor E, et al. Environment of infants during sleep and risk of the sudden infant death syndrome: results of 1993-5 case-control study for confidential inquiry into stillbirths and deaths in infancy. *BMJ* 1996;312:191-5. (27 July.)

2 Blair PS, Fleming PJ, Bensley D, Smith I, Bacon C, Taylor E, et al. Smoking and the sudden infant death syndrome: results from 1993-5 case-control study for confidential inquiry into stillbirths and deaths in infancy. *BMJ* 1996;312:195-8. (27 July.)