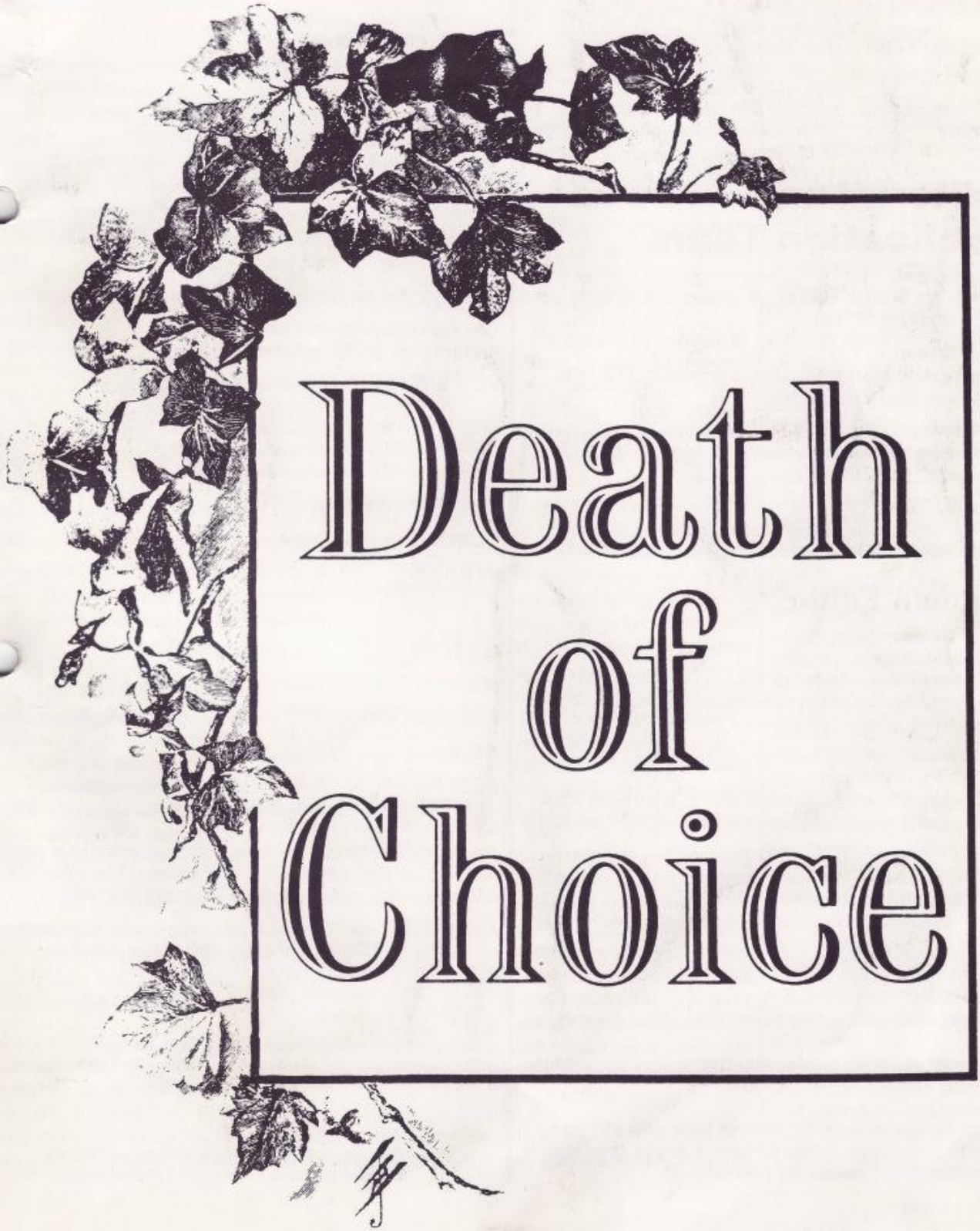
It is better to light one small candle
than to curse the darkness.

AIMS QUARTERLY JOURNAL

Association for Improvements in the Maternity Services

Vol. 1. No. 1. 1989 £1



Death of Choice

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GP UNIT SPECIAL ISSUE

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ISSN 0265-5004

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DEATH OF CHOICE

Editorial

In this special issue of the Quarterly Journal we have departed from our usual format to present an issue of vital importance to everyone involved in the maternity service. The run-down and closure of 'isolated' GP Units.

Over the last few years AIMS has become increasingly concerned by the escalating closure of GP units, that no amount of protest or pressure has halted. We have finally agreed that unless something is done NOW we will be facing a very bleak future where mothers will have less choice than they did 30 years ago.

When AIMS was first established in 1960 one of its first campaigns was to fight for more choice to be made available to women. Many mothers had decided they did not want to have their babies at home as their mothers and grandmothers before them. They wanted to take advantage of the new facilities that the 'free' NHS could offer and have their babies in hospital. Many were denied that choice because there were not enough beds to go round. The campaigns were fought and that demand was fulfilled.

Ironically, we have gone full circle. Today, thirty years later, we are back where we started. Fighting for more choice to be available to women. This time the battles are of a very different order. They are rearguard actions to preserve choice, not to provide it.

It could be argued that GP units are only one aspect of the maternity service and we should be fighting for all the other choices - but the buck stops here. It cannot be emphasised too strongly that if the GP units go, then all other choice will rapidly follow them into oblivion.

Experience of post-closure service shows all too clearly that GP involvement in intrapartum care rapidly declines. Distances to the DGH where GP 'facilities' are offered, are often too far for adequate cover to be arranged. Partners refuse to cover for those still interested, further reducing the numbers of GPs offering care. Even when the facilities are near enough, the GPs soon find the more stringent booking and operating policies enforced by the consultants in 'their' unit, reduce their suitable deliveries even further.

As deliveries decline so do skills and confidence, and GPs become more and more reluctant to undertake care. Active discouragement of home birth soon follows for the same reason, and finally the GP withdraws from intrapartum care altogether. In this respect I have to disagree with Dr. Gavin Young when he states in his paper that by and large GP care in integrated and attached units is not under threat. It is only the next stage. Dr. Kevin Thorley's experience at North Staffs where closure threats prompted his cost study, confirms this view.

But, as Gavin Young so aptly reminds us we do not forget that it is MIDWIVES who deliver, and the closure of GP units affects them and the resulting pattern of service far more seriously.

GP units are run by the midwives, where they use their professional skills to the full. The fine safety and satisfaction records of the units probably have more to do with the standards of their care than all the GPs put together. Closure of these units probably results in more midwives leaving the profession than any other cause. One day in charge, practitioners in their own right, the next obstetric nurses 'under' junior doctors at the DGH.

Even those who manage to obtain community posts, soon find that the one way funnelling Nancy Stewart highlights in her contribution, soon reduces their caseload to single figures. Without GP cover they cannot deliver in the DGH, and pressure from the medical profession compounded by 'withdrawal' of the obstetric flying squad, soon begins to affect even those few home births they are skilled and willing to undertake. Satisfaction declines with the inability to offer the continuity of care they are trained to provide, and finally many leave the service altogether.

So where do we go from here? The failure to save virtually any unit as confirmed by government figures published in this issue leaves little hope for the future. Joan Knott's 'Diary of a Closure' which vividly illustrates how to do everything right, and still lose confirms the futility of local action.

Hope can only lie therefore in a fundamental change in national policies.

We can no longer ignore the reality that it is government underfunding that is forcing Health Authorities to make short term savings by closing down small GP Units. There has to be an evaluation of the long term consequences. This CANNOT be carried out at district level.

National maternity policies must be reviewed. Health authorities all over the country are justifying and shoring up their local closures with national policy recommendations. That these policies have been formulated and based on professional opinion and not evidence as Gavin Young so clearly points out in his paper, is nothing short of tragic.

General practitioners must examine their position and determine their direction and future. The formation of a new independent GP obstetric association is one step in the right direction.

Midwives hold the key to the future. It is they above all others who must have the courage and determination of their convictions and recapture the central position in maternity care. The slide into American style obstetrics must be halted.

Nancy Stewart concludes her article.....'Coherent argument can expose the fallacies in the logic of closures, but only a more deeply rooted and widespread change in the assumptions on which maternity care is based will cause a real about-face.'

This is the challenge. Without this change we will soon be faced with the death of choice.

Hana Blackmore.

LETTERS

Letters

HOME BIRTH AVAILABILITY

We moved here to Binbrook, Lincolnshire 15 months ago and I interviewed various GPs before deciding on which one to register with.

We live 13 miles from Grimsby (in Humberside) and 24 miles from Lincoln -our two nearest maternity units. Approximately 2 years ago there was a unit at Louth (10 miles away but quick through country roads). My findings resulting from the closure of the Louth Unit caused me some sadness.

The village GP's wife said her husband would do a home delivery if asked to because he loves children. He later informed me that he wasn't actually allowed to do this because of the local consultants, and still later said he now has permission to do so. (She also said he hadn't practised homeopathy in the 30 years she'd known him but she was sure he would have a go. Not wanting to be homeopathic or home birth guinea pigs I decided against him).

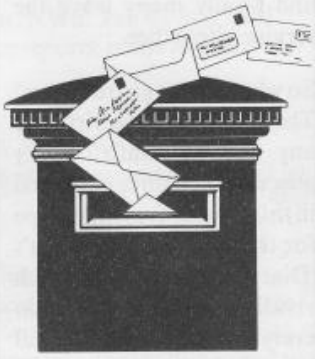
The GP at North Thoresby said that the Grimsby GP unit was so good that he would not agree to attend a home birth, but is very pleased to do GP unit deliveries.

The GP in Louth was very practised at home confinement while the hospital in Louth had a maternity section, and was also familiar with GP unit deliveries. He now, however, will not agree to attend a GP unit delivery due to the distances involved. (Grimsby/Lincoln), and is not too happy with home confinements either, due again to distances involved and the nature of the local flying squads. I believe the Grimsby hospital-based squad will not attend in Lincs. He did, however, agree to consider attending a home confinement and so I registered with him as the one most likely to. I know a GP is not an essential ingredient, and I had my first baby at home (an initial battle until I found the right GP), but I'd like a helpful GP if the need arises.

We do have an added bonus here of a locally based, much underused independent midwife.

Yours and all the best
Sheila Pickard

PS. I now understand that there is no flying squad because the hospital consultants do not recognise a need for home births.



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NEWS

News

NEW ASSOCIATION TO BE SET UP TO SUPPORT GP OBSTETRICS

Over 100 enthusiastic GP obstetricians at last got their act together. At a meeting in late February it was agreed to set up and establish an independent Association to support and encourage GPs involved in intrapartum care.

The meeting organised in Birmingham by the West Midlands Faculty of the Royal College of General Practitioners heard from GPs across the country concerned about the continuing threat to GP units, and the lack of national organised support.

Local successes, from new units to increasing demand by consumers balanced the bad news, and it was agreed to set up a steering committee to get the new organisation off the ground. Initial contact is Dr. Gavin Young, The Surgery, Temple Sowerby, Penrith, Cumbria CA10 1RZ.

NCT CONDEMNS CLOSURE OF SMALL MATERNITY UNITS

The National Childbirth Trust in a press release of March 1989 views with alarm the rising rate of closure of small maternity units in spite of vehement protest from consumers. They claim that at present there is no evidence to support the claim that the safest policy is for all women to give birth in specialist units, and that closures in rural areas are forcing women to travel considerable distances for their antenatal care and delivery.

The NCT question the supposed financial savings of closures in view of the fact that no comparable figures have ever been issued, and ask whether the District Health Authorities have taken into account the expenses created by such closures.

The right of women to choose where to give birth is emphasised. The NCT believe that women should be given clear information about the availability of services and then be allowed to make their own decision about where to give birth. They question for whom the service is being run when local people do not want these units to disappear and the case for closure has not been established.

AIMS DEPLORES FAILURE TO RECOGNISE MIDWIFERY STATUS

The following press statement was issued by the committee of AIMS at its meeting on 26th November 1988.

"AIMS deplores the failure of the NHS in the recent regrading exercise to give proper recognition to the independent and professional status of midwives.

The role of the midwife in

pregnancy and childbirth is of prime importance and in the implementation of the regrading scheme AIMS feels a crisis point has been reached, witness the unprecedented threatened resignations of midwives.

The government's recommendations as set out in "Maternity Care in Action, the most recent report on maternity services, emphasise the essential nature of midwifery care for thousands of women giving birth each year.

The pressure put on managers by the Department of Health to meet budget requirements has led to widespread downgrading of midwives in many parts of the country. It is essential that the position is reviewed as a matter of urgency. Mothers and babies require a properly recognised and funded midwifery profession for their health and safety."

INTERNATIONAL DAY OF ACTION FOR WOMEN'S HEALTH

May 28th 1988 was the first International Day of Action for Women's Health, dedicated to the prevention of maternal mortality and morbidity. In 45 countries, more than 100 women's health groups, activists and health care providers participated by organising a wide range of activities.

This year the Women's Global Network on Reproductive Rights call on women's health groups and everyone who supports reproductive rights for women all over the world to join in their campaign on May 28th 1989.

For more information contact them at:
Nieuwe Zijds Voorburgwal 32,
1012 RZ Amsterdam,
Netherlands.
Tel: (31-20) 20-96-72

DEATH OF CHOICE

A BASIS FOR CLOSURE?

SANDAR WARSHALL draws on AIMS cuttings and files in search of any rhyme or reason for closing GP units.

There can be little doubt that GP units and Maternity Home closures have been brought about by the underfunding of the NHS. Health Authorities find themselves with little money to provide or improve their present level of service, as well as having to fund higher pay awards. In the past authorities have had the money to support these facilities. No policy decision against them was made. However, they are closing and, thus, disappearing from the communities by default.

HA's are compelled to make their budgets balance - an impossible task without decreasing services. Sadly, long term consequences have not been considered. This coupled with the government's aim of 'centralisation' has meant that maternity homes and hospitals and GP units, could be cut under the guise that new, central, high-tech units would adequately replace them.

There is quite a large spread in the amount which HA's hoped to save, amounts from £25,000 to £200,000 were mentioned. Some hoped these monies could be put back into community care. Others wanted to sell buildings and use the money for other things. Many felt that the underused maternity home could be better used for care of the elderly or residential or help for the mentally ill, for example. All of these are pressing needs that must be prioritised. In all cases, one felt that HA's were desperately trying to make the books balance while still providing some modicum of care. Many HA's and certainly CHC's expressed deep regret at their choice and were not happy with their task.

One thing is clear - closing homes and selling assets will not solve the problems caused by underfunding of the NHS. Eventually, false economies and sold assets will cost people dearly.

Almost no GP unit or maternity home was closed without a protest, and the lure of tiny babies and adoring mums proved irresistable to local journalists. Much of my research was based on newspaper clippings covering the period 1986 to the present. Local journalists were almost consistently sympathetic to the community.

Community organisation to protest the closures was impressive. Petitions were collected, some having as many as 15,000 signatures. Letters were sent, marches were organized, and evidence proving the value and worth of the unit was produced. "Friends of....." groups raised money and kept campaigns growing. Sadly, they seem to have had little success. Some groups vowed to remain intact after the maternity home or unit was closed, hoping to monitor the effect of the closures in the future. The battle lines were frequently midwives, users, and GPs versus the RHA and consultants.

One reason for a unit's closure was 'lack of use'. Upon investigation, this was a rather cynical reason, as once a unit was threatened with closure, people felt unsure about booking into it. In many cases, admissions had been stopped before figures were collected. By the time groups were aware that they might lose their local facility, numbers of births were indeed very low. Sometimes women were not told their choices and felt they could only 'choose' the local hospital.

In one case, the RCOG threatened to withdraw recognition of Junior Doctor training at a home because maternity cases with complications were sent to the large, high-tech hospital. Interest in normal birth was not encouraged.

The word "use" must also be looked at as, although the number of births might have been low, many women chose to lie-in at the small community units. Here the long term good of postnatal care could be best experienced. Mothers often spoke with appreciation of the time spent helping them to establish breast feeding and dealing with all the worries and concerns they felt as new mothers.

However this period of individual attention was not considered as an important 'use'. The idea most frequently

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expressed was that small units were under-stocked (with high-tech equipment) and over-staffed with midwives. A more obvious statement of ignorance about what mothers need, could not be made. (This reveals a basic misconception about what women need and want).

The argument that closing small 'isolated' units would save money did not take into consideration the many additional expenses that would arise. If midwives were to leave small units with that particular ethos and be moved to larger, high-tech hospitals, a certain degree of re-training must be expected.

Once in hospital, births often become more expensive as machines and drugs are more often employed and these are costly to buy and costly to maintain. Postnatal care is often less ably dealt with in busy hospital units, putting extra need on health visitors and community midwives. Since women will be removed from their local community to give birth, ambulances must be available for all those people who do not drive or have cars. If ante-natal care is also removed, transport allowances must be increased.

Many groups have tried to make cost comparisons but statistics proved very difficult to correlate. Does one compare cost-per-day; cost per bed; midwife versus consultant time; full unit to half empty unit? length of stay should also be taken into account, but varied tremendously

GPs get paid for each birth by the FPC, whereas a consultant, who is more expensive, is paid by the HA. Hospital staffing levels must increase to cope with the increased clientele. One is left wondering if any substantial saving will be made or is it all going to prove much more costly than the present, thus bringing about the need for more cuts.

Another often cited reason for closure was small units are 'unsafe'. Consultants and HAs often equate safety with equipment even though there is a growing body of evidence to refute this. Dr. Rosen's Report of the Association of Anaesthetists on obstetric services has also fuelled this thinking although his findings have been called into question and many of his statements challenged.

The fact that many women require transfers from small units to large hospitals was given proof of small units incompetence. In fact, many of those numbers were women who had delivered safely, but had sick babies, women wishing sterilisation etc. Screening procedures were often employed which left only the most straightforward deliveries in the units. Breech births were sent to big hospitals thus de-skilling midwives and raising the number of transfers.

The closure of GP units and small maternity homes is symptomatic of two things. One is the slow loss of services that villages all over Britain are experiencing. Schools, transport, bus services, post offices are all being centralised and taken away from small communities. GP units are just part of that slow decline.

The other aspect is that people campaigning for a re-appraisal of birth in this decade are losing the battle. None of their views or findings have dissuaded an HA from its decision to close small units.

Birth in small, homey places has been devalued. It is no longer seen as safe and sensible. It is seen as expensive, wasteful and a 'luxury we can no longer afford'. What was once considered of primary importance is now a luxury and an 'unsafe' one at that.

The value of woman feeling protected and cared for at this particular time in her life is discounted. The establishment of breast feeding is not of major import. The needs of the family and children to be near their mother, visiting and rejoicing are not considered relevant. Even the physical difficulty of making it on time to the hospital - up to 20 miles away on difficult roads - is not taken into account when closures are made. None of these arguments seemed to have any bearing on the decision makers. The only argument that did prevent a unit closing was proof that the birthrate in that area was rising.

The midwives who run the smaller unit had often been working together for years. They did ante and post-natal checks as well as deliveries. They knew the women and their families - valuable information that ensured proper care for each individual. They are now asked to work in large hospitals or are offered jobs in the community. I read of no redundancies but did read of many midwife shortages throughout the country.

Is this, in fact, a chance for midwives to call the tune? Should they now insist on their rights as independent practitioners? Many of the midwives who worked independently in small units have a unique ethos and body of knowlege which they must retain. Perhaps, they will implement the changes in hospital practices that many people feel should take place.

These large centralised hospitals are also feeling the pressure. Women feel harassed at having lost their right of choice. They must now try to get a home birth or submit to the system used in the local hospital. Perhaps. hospitals will see the wisdom of continuity of care and a more homey atmosphere and ethos in order to lessen the hostility many women feel. None of us can rejoice at this loss to women. But as the failures in the new system are thrown up perhaps exciting alternatives will emerge.

Home birth was often mentioned as an alternative to a long trip to hospital or a birth far from friends and family. The midwifery service should be prepared for an increased call for their services in this capacity. It is a fine opportunity for midwives to regain their place as the professionals in normal pregnancy and birth. Women will welcome the possibility of this choice as they are suddenly finding themselves with very few options. One hopes the profession can be prepared and willing to make this possibility a reality. The benefit to women will be enormous.

Maternity Care in GP and Consultant Units: A Study of Comparitive Costs

Peter Taylor, BA, MA
Kevin Thorley, MA, MB, B.Chir., MRCGP, DRCOG

Summary

In the debate about GP obstetrics, it is often assumed that GP units on site in maternity hospitals are inefficient in terms of cost. The assumption is usually based on bed occupancy rates. This study compares the average costs of a normal delivery on the GP unit at North Staffordshire Maternity Hospital with that of a normal delivery in the Consultant unit of the same hospital. These costs are higher for the GP unit, but further analysis shows that small, feasible changes in medical policy can result in large changes in relative costs. A full cost-benefit analysis is not considered feasible for district health authorities, because not all the data required are readily available and the estimation techniques are uncertain. A more probable basis for actual decision about the future of GP units is one which includes average costings of the type found in this study. However, such decisions need to consider not only cost comparisons, but also the relevant and alterable medical policies on which the cost comparisons depend.

Introduction

The last decade has seen an increase in the proportion of births in hospital under consultant care compared with births under general practitioner care at home or in GP maternity units, many of which have closed. The consequence of this trend has been a decline in general practice obstetrics, yet a recent study has cast doubt on the premise that specialist care leads to greater safety (1). This premise is one of the factors which have motivated the move away from GP obstetrics.

General Practitioner Units on site at maternity hospitals have been shown to give safe care for low risk cases and they may be preferred by mothers (2,3,4,5). They have also been shown to have lower average bed day costs than specialist consultant units, although the difference varies considerably according to the study (6,7)/ One problem in such cost comparisons is allowing for the fact that consultant units deal with abnormal as well as normal cases. If this fact is not treated explicitly in the comparisons, it leaves an important question unanswered: "are the cost differences between the unit types justified by their clinical differences?" Gray and Steele (1981)

One way of avoiding such an imponderable is to ensure the comparison of like with like in the first place. It is the intention of this paper to use a case study to compare relevant costs of ***normal*** cases in a consultant maternity unit with those in a GP unit. In doing so, we also draw attention to two other related matters - the sensitivity of relevant cost comparisons to policy changes, and the feasible boundaries of such a comparitive cost study for decision makers in charge of resource allocation to maternity care.

The General Practitioner Unit at North Staffordshire Maternity Hospital is a twenty-two bed ward, with two labour rooms, situated on the sixth floor of the hospital. The labour wards are fully equipped for resucitation and the consultant labour wards, operating theatre and special care baby unit are on the ground floor, allowing rapid transfer of patients in an emergency.

During 1985 it became apparent that the unit was being investigated by the District Management Team with a view to closure, or assimilation within the consultant unit. We decided that a study of the costs involved in GP obstetrics would be of help in the public debate and decision making process both locally and nationally.

Method and Analysis

The cost comparisons between the GPU and the CU are initially based on staff costs. Hotel costs per patient are likely to be very similar. Capital costs, although likely to be higher in the CU, are difficult to estimate because proper allowance for depreciation requires calculation of the rate of physical deterioration and the replacement cost of all capital equipment. In our concern to compare like with like we also concentrate initially on intra-partum and postnatal care costs, since these are the only functions undertaken directly by the GPU. We therefore exclude

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consideration of the CU antenatal wards. However, we do consider the costs incurred by normal patients attending antenatal clinics, since the type (CU or GPU) of intra-partum and postnatal care has a direct influence on the antenatal travelling and waiting costs of the patients.

The cost estimates are ***average*** costs, since compared with marginal costs these are more stable in the face of short run capacity utilisation changes, and more calculable for a district health authority in a practical, decision-making situation.

A distinction is made between cost to the District Health Authority (DHA) and cost to the NHS. The major difference between these two is that GP maternity fees are paid from funds outside the DHA budget. In 1984 this fee was £100 per case if the GP has total responsibility and £73.05 for maximum 'shared care' (implying that the GP takes all the antenatal responsibilities). We therefore took the difference between these, £26.95 per case, as an approximation for the part of the GP fee which covers intra-partum and postnatal care in the GPU. We suggest that resource allocation decision making is influenced primarily by those costs that are the immediate responsibility of the decision-making organisation - in this case the DHA. However we include, for comparison, consideration of costs to the NHS as a whole.

A major problem in comparing staff costs is that of common costs, a familiar difficulty for economists. Whilst nursing and ancillary staff are allocated specifically to each unit, medical staff on the CU have other functions -including gynaecological theatre and outpatient work, and ward work. In order to compare GPU and CU medical staff costs, those costs associated with intrapartum and antenatal care must be separated out. A simple way of doing this is to apportion them in terms of time spent in each activity as laid down in duty rosters and consultant contracts. In our North Staffordshire example this means, for practical purposes, taking one-third of the consultant costs and one-half of the senior registrar, registrar and senior house officer costs.

For our purposes the main common cost problem is that CU staff are responsible for abnormal as well as normal deliveries, whereas the GPU only deals with the latter. We therefore decided to estimate the proportion of normal and abnormal deliveries performed on the CU and weigh these proportions by the average lengths of stay for normal and abnormal patients respectively. By this calculation 59% of CU costs are relevant to normal cases.

Two of the policy decisions that affect the cost comparisons are the number of transfers from the GPU to the CU, and the average length of stay in each unit for patients who have had normal deliveries. Patients transferred between the two units were studied and an assessment made of the need for transfer in each case. The data were drawn from the ward records. The average length of stay for patients on each unit was derived from the ward records for one month, April 1985. This was calculated as the actual mean length of stay from individual patient records, and not derived from Hospital Activity Analysis because this does not operate in the maternity hospital.

Further cost comparisons are therefore calculated, taking account of reasonable variations in lengths of stay and numbers of transfers, to test the sensitivity of the comparisons to these policy decisions. Sensitivity is also tested with respect to a third policy variable, the number of bookings made by GPs for the GPU in the third place.

The one element of social costs included in the comparisons is antenatal clinic visiting costs incurred by patients. A survey was made, by questionnaire, of sixty patients attending three different GP clinics in North Staffordshire and 173 patients attending the antenatal clinic at the hospital. Patients were asked three questions relating to waiting time, travelling time and costs. To calculate the total cost savings to be made by a feasible shift of five per cent of cases to GP clinics, we divided patients' time savings into full-time working time, part-time working time, and non-working time, according to the national and regional labour force activity rates and employment data for appropriately aged females (16-44 years) in 1984. The full-time and part-time savings are valued at relevant average hourly earnings. Non-working time savings are valued at 25% of full-time hourly earnings, a proportion commonly used in transport studies.

Results

The unadjusted cost estimates for 1984 are presented in Table 1. The annual total staff costs for a CU postnatal ward are £111,805, some 43% higher than the equivalent GPU costs for the DHA, or 15% higher than the GPU costs for the NHS as a whole. The cost per normal delivery on a CU ward was £86, while that on the GPU was 36% higher for the DHA and 69% higher for the NHS as a whole.

TABLE 1. Actual Staff Cost Comparisons for GP Unit and Consultant Unit Wards, Normal Deliveries, 1984

(£)	Anual Ward Costs	Cost Per Delivery	Cost Per Bed-Day
CU	111805	86	27
GPU (i) DHA	78303	117	41
(ii) NHS	97518	145	51

Although bookings in the GPU rose during the years 1981-84, the number of deliveries carried out on the unit actually decreased. This was because of a rising number of cases transferred to consultant care. The number of transfers from GPU to CU for the years 1981-84 are shown in Table 2. The totals in this Table ignore those patients delivered on the CU and returned for postnatal care, since these would not be included in the GPU's total deliveries figures and policy changes would not affect these transfers (see later).

464 antenatal patients were transferred from the GPU to consultant care during 1984. Analysis of the reasons given for transfer, shown in Table 3. indicates that 239 (52%) of these were transferred for indications which were absolute - necessitating transfer in every case. Such indications included ante-partum haemorrhage, cephalo-pelvic disproportion, placenta praevia and serious medical conditions in the mother. A further 7 transfers (1.5%) were cases with previous caesarean section or Kiellands forceps deliveries who were unsuitable for GPU booking in the first place. 170 transfers (37%) were for relative indications which may have been decided on clinical judgement in each case, but where treatment or further investigation could have been given by the GP, such as 'low haemoglobin', premature labour, weight loss, and hypertension. 35 (7%) of the transfers seemed unnecessary, for example, urinary tract infection, 'unsure of dates', vaginal discharge, back pain.

Table 2. Transfers Between GP and Consultant Units, 1981-1984.

	1981	1982	1983	1984
Deliveries on the GP Unit	761	713	706	672
a) Antenatal period transfers	404	402	477	464
b) Returned	104	88	100	90
c) Transferred during labour	79	103	89	138
Returned after labour	42	55	38	78
Net Total Transf (a+c-b)	379	417	466	512
Transfers as percentage of GPU Bookings	33	37	40	43

Table 3. Indications for Transfers from GPU to CU

(Numbers in Parenthesis = those returned to the GPU after consultant assessment)

Absolute Indications		Relative Indications		Unnecessary	
Premature labour	40 (1)	Elderly primp	1 (0)	Urinary tract infection	6 (1)
Breech	35 (2)	Poor obstetric history	11 (0)	Unsure of dates	15 (0)
Raised AFP	8 (1)	Rubella	1 (0)	Oedema	2 (0)
Others, eg		Small stature	15 (2)	Requested sterilisation	3 (0)
[illegible]ta praevia, [illegible]riage	156 (0)	Post maturity	41 (9)	AID	1 (0)
		Raised BP	65 (8)	No reason given	9 (0)
		Decreased fetal movements	9 (0)		
		Low Hb	5 (0)		
		Glycosuria	2 (0)		
		Abdominal pain	3 (0)		
		Hypermesis	2 (0)		
		Back pain	2 (0)		
		Weight loss	2 (0)		
		Non-attender	4 (0)		
		Multiparity	7 (2)		
TOTALS	**239 (4)**		**170 (21)**		**35 (1)**

Note: For 64 returned patients the reasons for original transfer are not known

If the 35 unnecessary transfers, together with one half of the patients transferred for relative indications, had ***not*** been made, or if the patients had been returned to GP care following consultant assessment, then another 120 patients would have delivered on the GPU. The effect on costs is shown in Table 4 (a). Although total ward costs remain the same, the cost per delivery on the GPU falls to £97, and the cost per bed day to £34 as far as the DHA is concerned.

Only 90 (14%) of the 464 patients transferred to consultant care were returned after consultant assessment. Of these, the reasons for transfer are known for just 26. Interestingly, some of these were for 'absolute' indications according to our categorisation. Table 3. details the nature of the returned cases. In addition to the 464 cases transferred during antenatal care, a further 138 patients were transferred to consultant care during labour. A review of the indications for transfer suggests that few if any of these transfers could have been avoided.

The average length of stay for an abnormal case on a CU ward was 5.6 days, whilst for normal cases it was 3.16 days on a CU ward and 2.86 days on the GPU. Table 4 (b). shows the costs of a normal case bed day on the CU as if the average length of stay were the same as the GPU, since there are no obvious medical reasons for any differences for normal patients. The effect is to cut by a third the difference between bed day costs of the GPU and the CU, as paid by the DHA.

In 1984, 85 per cent of the normal deliveries at the North Staffordshire Maternity Hospital were conducted on CU wards and 15 per cent on the GPU. If a 5 per cent shift in these proportions were to be encouraged in favour of the GPU, the costs per bed day paid by the DHA would be about the same on both the CU and the GPU, whilst costs per delivery would be lower on the latter, as shown in Table 4 (c).

Table 4. Sensitivity of Cost Comparisons to Hypothetical Policy Changes, 1984

(£)	Cost per Delivery	Cost per Bed-day
a) 120 less transfers from GPU to CU		
CU	89	28
GPU (i) DHA	99	35
(ii) NHS	123	43
b) Same length of stay		
CU		30
c) 5% shift in original bookings		
CU	92	29
GPU (i) DHA	86	30
(ii) NHS	107	37
a) + b) + c)		
CU	95	33
GPU (i) DHA	76	26
(ii) NHS	94	33

The final part of Table 4. shows the cumulative effect of all three changes in policy - reduced transfers, same length of stay and more GPU bookings.

Other relevant considerations are that in the period 1981-4 there was one stillbirth and no perinatal deaths on the GPU in 2852 deliveries. This gives a perinatal mortality of 0.35 per thousand. In 1984, one stillbirth and one perinatal

death occurred among the 138 patients transferred during labour. This gives a perinatal mortality of 14.5 per thousand for patients transferred from GP to consultant care. The perinatal mortality for the CU for 1984 was 18.04 per thousand. The national perinatal mortality for 1984 was 10.0 per thousand.

The results of the survey to evaluate comparative costs to patients from antenatal clinics are shown in Table 5. The median costs and times are more appropriate measures of central tendency, since the distributions are all positively skewed. In each case the time and money costs of the GP patients are significantly lower than those of the consultants' patients. A total of 28,667 visits were made to the hospital antenatal clinic in 1984. Assuming these to be 85% of the total antenatal visits in North Staffordshire, a shift of 1686 visits to GP clinics would represent a five per cent shift in the total visits. The total annual savings arising from such a shift would have been £3,099 in 1984, or £1.84 per 'shifted' visit.

Table 5. Antenatal Clinics: Patients' Money and Time Costs

	Median	Standard Deviation
a) Visit Costs (pence)		
Hospital Clinic	93.2	82.8
GP Clinic	30.6	37.8
b) Travel Time (minutes)		
Hospital Clinic	24.7	19.3
GP Clinic	8.6	6.9
c) Waiting Time (minutes)		
Hospital Clinic	38.0	33.2
GP Clinic	18.6	15.2

Discussion

The different results emerging from our cost comparisons may be interpreted in two ways. First, they may confirm the impression that anything can be proved with statistics and that such evidence should be mistrusted. However, such data may be seen as inevitable inputs to the decision-making process and we feel that the best possible use should be made of them. We therefore prefer the alternative interpretation that cost comparisons are helpful but should be fully supported by information about the policy variables on which the cost estimates depend, and how policy changes might alter the comparisons. Length of stay, transfers and encouragement of GP obstetrics are three such policy variables which may significantly affect comparitive costs.

The number of transfers from GP care to consultant care have risen steadily over the last four years in our case study, with the result that while bookings into the GPU have increased, the number of deliveries has decreased. It is most unlikely that this is due to changes in morbidity in North Staffordshire, and the conclusion must be that this phenomenon results from changes in medical policy. These changes have caused the GPU to appear less efficient in terms of bed occupancy and average costs over time. If the trend were reversed then delivery on the GPU would become more economical. This is inevitable in a service dominated by fixed costs, such that any increase in capacity utilisation is most likely to reduce average costs.

As it stands, the CU averaged 59% capacity utilisation in 1984, while the GPU only managed 41%. The highest monthly average capacity utilisation for the CU was 62% and for the GPU, 55%, indicating a problem of overall excess capacity in North Staffordshire Maternity Hospital which no doubt prompted the investigation into the role of the GPU. So the opportunity costs of shifting cases from one unit to the other are fairly low in this example. Of course, if either the CU or the GPU wards ever ran at 100% of capacity then any change in transfer or bookings policy would have consequences for the total costs of the units and the efficiency with which scarce space resources were utilised. As this is not the case in our example, our main immediate concern is to show that any differential costs (and capacity utilisation) are the result of certain policies which are not irreversible. The combination of these policy outcomes and the excess capacity problem gives, we suggest, a misleading impression of the relative cost efficiencies of the CU and the GPU.

There are four measures which would help to achieve the objective of reduced transfers. First, encourage more active participation of GPs. Transfers might be avoided if there was more consultation between GPs and midwives about cases. Secondly, press for an increase in GP maternity fees under the reorganised obstetric list, rewarding those GPs who use their obstetric skills. From an economist's point of view low fees will cause GPs to make the decision that a patient with high marginal costs, in terms of time input needed, is worth transferring to consultant care. A higher fee would be a greater incentive to practise obstetrics against the high marginal (time) cost involved. Thirdly, appoint a panel of GPs with special experience in obstetrics for peer review and consultation about doubtful cases. Finally, encourage consultants to act as consultants and to return low risk cases to GP care. The data show that this does not seem to occur frequently enough.

A major influence on the capacity utilisation and hence the comparitive costs of the two types of maternity unit is the attitude of local GPs. If they have not received sufficient encouragement to use the unit, or if they perceive a disincentive, then methods need to be found to correct this. This is another research question and a survey of GP opinions in North Staffordshire is to be undertaken as the next stage of this research.

The scope of this study has been deliberately restricted in two ways. First, it examines only costs and ignores benefits. Second, it has only estimated those social costs represented by the 'locked-in' costs to patients of antenatal visits. A full economic appraisal would not acknowledge such limits. The principles behind the

technique of cost-benefit analysis are concerned with maximum social welfare, taking ***all*** relevant costs and benefits into account. In the case of comparisons between GP and Consultant care this would involve, in addition to our considerations, the following:-

1) The comparitive benefits of the two types of unit for patients. Consultant units have greater stocks of both equipment and specialist skills with which to service both abnormal and normal cases. On the other hand the GPU may also yield benefits to normal patients. The view that women prefer GP care in 'low tech' surroundings seems to be gaining ground and some studies have suggested that greater patient satisfaction is associated with GP care (8,9). This is probably due to continuity of care for women by their family doctors and attention to psychological and emotional factors associated with birthing. There is evidence that anxiety not only raises the blood pressure in pregnancy in the antenatal clinic, but is also associated with low birthweight (10). The GP unit provides a relaxed atmosphere without the stresses induced by strange equipment and with the advantage of reassurance from familiar people giving care - the community midwife and the family doctor.

2) The true cost of GP and consultant time, i.e. the opportunity cost of the time spent in care of normal maternity patients. This would include the greater care that might be given to abnormal cases by consultants and the 'next best' alternative use of time for GPs.

In both of these extensions to the economic appraisal there are great difficulties in valuation, so that it is unlikely to be feasible to conduct them at the district level. The valuation of psychological and emotional benefits from delivery in a more relaxed atmosphere in the GPU requires sophisticated survey techniques which are unlikely to be employed by the DHA in an option appraisal. The benefits derived from skill and technology in the CU are not only the subject of medical debate, but their valuation is one of the most controversial exercises in cost-benefit analysis, i.e. the value of human life. Life valuations have been estimated empirically, but these estimates should not be 'borrowed' for a study such as this since they are neither specific nor stable enough to be appropriate. (For brief reviews see 11, 12 and 13).

Furthermore, a full cost-benefit study would not confine itself to the two types of unit. It would include all appropriate options such as home delivery, remote GP units and different mixtures of such options. We think it unlikely that a decision-making authority faced with limited time and information would undertake such a complete study - the relevant North Staffordshire Health Authority option appraisal did not, for instance. Such constraints are the reasons for our explicit discussion of the feasibility of cost-benefit analysis at the district health authority level.

Modern theories of decision-making in bureaucracies commonly acknowledge the constraints in the concept of 'bounded rationality', that is rational decision-making bounded by a limited amount of knowledge, skill and time. These limitations imply that cost comparisons such as those we have calculated are more practicable than cost-benefit appraisals which, furthermore, are more speculative as well as being more sophisticated.

Conclusions

This study has shown that the average costs of the two units are different, but sensitivity analysis suggests that a small change in relative medical policies can result in quite a large change in the relative costs of the units.

A full cost-benefit analysis of maternity care options is not considered feasible at district health authority level, given the uncertainty of estimation techniques and the limited resources of the decision-making authority. Simpler cost comparisons ARE possible and they can be of sufficient detail to assist decision-making. However, they can also appear misleadingly unfavourable to a GPU, giving rise to policies which result in a further deterioration of its relative costs.

Such a situation will probably arise from ***implicit*** rather than explicit policy decisions, so no-one is necessarily to blame for such a situation. However, a time of reappraisal is an opportunity to reveal the historical factors behind the current cost comparisons. Attention should be drawn not only to the comparisons per se, but also to the policies that have led to them. The decision-making would then need to cover not only the size or continued existence of the GPU, but also changes in related policies, such as the transfer of patients to consultant care and the encouragement of GPs to participate in their unit. A narrow decision, based on the immediate comparative costs of the two types of unit would be entirely inappropriate.

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Diary of a Closure

A personal timetable of the events at Barton Hospital, Hampshire between 1978 and 1988

By Joan Knott, Midwifery Sister

22.6.79 District Management Team's proposal to close Barton Hospital made known to staff.

6.12.79 Deputation to see Dr. Gerard Vaughan, Minister of State for Health.

18.12.79 Barton Hospital closed temporarily for roof repairs. Fears that this was an attempt to close it permanently.

17.1.80 Area Health Authority endorsed district Management Team's proposal and set the statutory Consultative process in motion.

9.4.80 Public meeting called by the Community Health Council.

22.4.80 Question raised in the House of Commons by Robert Adley MP.

3.7.80 Community Health Council voted against closure.

17.7.80 Area Health Authority confirmed their view that closure should take place.

11.3.81 Regional Health Authority supported the closure proposals.

20.3.81 Dr. Gerard Vaughan, Minister of State for Health visited Barton Hospital.

30.3.81 Dr. Vaughan announced his decision that there should be a reprieve.

28.8.81 District Health Authority approved spending £48,000 during the 1981/82 financial year on essential maintenance work at Barton Hospital.

23.11.81 External repair work commenced.

1982 Plans made to close for the internal work to commence in March.

March The work did not start and the closure was delayed. Agreement reached that the money allocated for the work could be carried over into the next financial year.

June '82 New plans were made for the hospital to close on 28th June and for the work to commence on 5th July.

16.6.82 Tenders received for the work and found to be excessive.

23.6.82 Staff informed that the work could not take place as planned.

30.6.82 DHSS request for a review of the situation at Barton Hospital. Staff not informed of this until 10.9.82.

20.7.82 New timetable agreed for a reduced amount of work subject to satisfactory tenders being received. It was planned that the hospital should close on 1st October 1982 and re-open on 3rd January 1983.

27.9.82 District Health Authority authorised essential work only.

11.11.82 Deputation to see Kenneth Clarke, Minister of State for Health.

8.12.82 Letter from the DHSS Regional Principal to the District Administrator suggesting that the Minister 'would clearly wish to satisfy himself that every effort had been made, in the spirit of Dr. Vaughan's 'decision, to develop the Grove to its fullest potential'. Further factors were suggested which the Authority needed to take into account before proposing, once more, to close the Grove and proceeding to public consultation.

18.1.83 Question raised in the House of Commons by Robert Adley MP.

Feb 1983 Community Health Council voted unanimously to recommend to the District Health Authority that it should delay for 2 years the proposal to close Barton and that the upgrading work should be carried out immediately.

28.3.83 District Health Authority reject the CHC's recommendation and once more propose that Barton should close.

May '83 District Health Authority agree that Barton should be given a further reprieve and the work be carried out.

1.8.83 Barton Hospital closed for alterations, re-wiring and redecoration.

1.12.83 The building was re-opened.

1984 27% increase in bed occupancy. The only year which was free from harrassment by the Health Authority.

1985 Continued increase in bed occupancy.

20.12.85 Temporary closure proposed by the Health Authority due to a financial deficit in the District.

23.12.85 Protest meeting and march by the public who were appalled by this proposal.

30.12.85 Public meeting called and attended by about 300 people. It was agreed to try to raise the money which the Health Authority said it would save by the closure. The Health Authority asked that £3,100 should be paid immediately to keep the hospital open until 14.1.86, and an assurance then that the remainder of the estimated saving of £20,000 would be paid by the action group.

31.12.85 £3,100 paid to the Health Authority.

10.1.86 Representatives of the Action Group met with members of the Health Authority and reported that nearly £10,000 had already been raised by local people and the Health Authority acknowledged that the Action group was likely to meet its target of £20,000. It was agreed that the threatened temporary closure of Barton Hospital from January to March would not take place.

11.1.86 Petition of 10,000 signatures against closure given to MP.

17.1.86 Further meeting of representatives of the Action Group and the Health Authority. Agreement was reached on a revised assessment of the savings which would have been made by the proposed closure - £13,465, not £20,000. The Action Group agreed to pay the balance of £10,365 to the Health Authority.

March 1986 £10,365 paid to the Health Authority.

24.3.86 District Health Authority meet but delay a decision on Barton's future until a meeting on 28.4.86.

28.4.86 District Health Authority once more propose that Barton Hospital should close and set the statutory Consultative process in motion again.

19.5.86 Consultation Document issued.

20.6.86 Representatives of the Action Group meet with Norman Fowler, Secretary of State for the Health & Social Services, at Barton-on-sea.

8.7.86 Public meeting called by the Community Health Council and attended by over 600 people.

28.8.86 Community Health Council voted against the closure.

28.9.86 District Health Authority rejects the Community Health Council's counter proposals to the closure of Barton.

December 1986 Regional Health Authority endorse the proposal to close but refer the final decision to the Secretary of State.

29.6.87 Deputation to see Edwina Currie, Minister of State for Health.

1.9.87 Edwina Currie endorsed the proposal to close Barton.

29.2.88 Barton Hospital Closes.

THE SERVICE CAN BE PROVIDED MORE EFFICIENTLY ELSEWHERE (ONE DISTRICT'S PROVISION)

In 1981 the district had 21 GP beds (40% of total) in 2 GP units taking 30% of the cases. (16% of births). Two years later both units were closed. Today GPs have 'access' to 2 delivery beds at the 38 bed DGH consultant unit.

The following are extracts from the operational policy for those GP beds.

1. The Legal Advisor of the RHA states the prime responsibility for the care of the patient rests with the GP who is to retain clinical responsibility for the patient and the newborn child throughout the period of hospitalisation. If any negligence occurs in this period, it is the GP who is personally liable and not the Health Authority.

2. The Delivery Suite is available to GPs and District Midwives who are prepared to undertake the full care of the patient and her baby i.e. repair of the episiotomy, drips, sedation etc.

3. The GP patients would be looked after in the two single rooms, (in the delivery suite) subject to availability, but there will be no designated GP beds.

4. The consultants hope that the majority of the GP patients will only be in for a 6 to 12 hour stay, i.e. that they have the advantage of a hospital delivery and the benefits of home nursing, as they feel that a 48 hour discharge is not the best time to send a patient home.

5. Ward 18 will be available for GP patients who wish to stay longer than 12 hours, but if a stay of longer than 48 hours is required by the patient, a Consultant delivery should be arranged at booking. If complications arise at 48 hours the patient should be transferred to consultant care.

6. Hospital midwives will undertake the Post-Natal care of the patients in the Unit, as the Community Midwife cannot be available for 24 hours a day.

7. The patients booked for GP confinements should only be those considered suitable by the Cranbrook Report and should exclude Primigravid patients because it is impossible for a District Midwife to commit herself to look after the patient for an indefinite period.

8. The consultants expect the GPs using the unit to conform to the standards of management and procedures laid down for their staff.

9. Any problem in running the General Practitioner Unit (sic) should be reported to the Maternity Services Advisory Committee for appropriate action. For the smooth running of the unit it is necessary that all GPs follow this Operational Policy and the Maternity Services Advisory Committee would find it very difficult to support any individual who did not adhere to the policy. It is only by these means that the success of the GP involvement in maternity care in this district will be achieved.

Hana Blackmore

CONFERENCE

ANAESTHETIC SERVICES AND THE SMALL OBSTETRIC UNIT - ROYAL SOCIETY OF MEDICINE

Forum on Maternity & the Newborn.
28th September 1988.

"What are the justifications and implications of the recent OAA Report and how is the value of the small obstetric unit to be judged"

The debate concerning the recommendations made in Dr. Rosen's paper touch on some basic problems that those of us in maternity care always face.

One problem is that a man wrote the Report, so when he speaks of the pain of childbirth and what that means, he is truly ignorant. Michael Rosen, I believe is totally sincere in his concern. He sees that anaesthesia is an over-stretched department and he knows that statistics concerning maternal death from anaesthesia are the least improved. He sees the figures and is right to be alarmed. Sadly he makes the wrong conclusion.

His argument is that rushed caesars, flustered and over tired aneasthetists or worse, partly trained ones, cannot afford to make mistakes. Their actions result in death or severe brain damage, at worse; nausea and headaches at the least.

He sees small, isolated hospitals as the worst problem. By the time a flying squad is sent out, taking anaesthesia cover away from the general hospital, things are out of hand. There is no time to properly evaluate the situation and the equipment is not always standard. Dreadful mistakes are made and the sensible way to avoid this is closing down these far-flung units and bring the women into his "safe", well equipped hospitals. Seen this way, who could argue?

Interestingly, Selwyn Crawford could and he's dead! He had sent a letter to the meeting which was read out by Luke Zander. He called Rosen's attitude towards small units 'Autocratic and paternalistic'. Crawford acknowledged that a minority of women may need aneasthesia cover so a referral system or tier of help should be implemented. He stated that most mothers enjoyed the closeness and familiarity of small units and those who were at risk should be referred to the larger units where cover would be available. Crawford disputed the statements made about the safety of small units and said the "fact" that 1 in 3 labouring women use anaesthesia was "somewhat disingenous". Crawford acknowledged the value of epidurals for the minority but felt education and preparation were the greatest pain relief and that small units were best placed to achieve this.

John Hare of Hichingbrooke Hospital took a less aggressive stance stating that he had implemented many of the recommendations, however the conclusions of the report troubled him.

Luke Zander, charming and reasonable as ever, put his views over very succinctly. He said the report was a political document, well produced and well circulated. But we must remember that the orientation and objectives of the working party were biased, naturally by the profession that produced it. We at the forum are a multi-discipline group and we look at birth from many different angles.

Must we improve anaesthesia cover and thus lower the quality of maternity care? The 'experts' who gave their recommendations have moved outside their brief. Their domain is anaesthesia not maternity care and this explains the central controversy and confusion. We must assume the goodwill and kindly intentions of the report. (I always enjoy Dr. Zander's wonderful ability to distill the essence of a controversy and then to lethally present his case).

Zander pointed out how pain relief has changed in maternity care. He spoke of the proven values of personal contact, familiar surroundings and continuity of care. The report wants women to give birth in large central hospitals, just where the above situation does not exist. They will be offered the latest drugs, that is true, but the tide is moving away from this option.

Zander informed Mr. Rosen that midwife and GP unit care resulted in less complications and better outcomes. It seems the introduction of 'specialist' care causes the problem. Luke Zander also favoured better selection and screening so those in need would be catered for.

Finally, he stated, Rosen's recommendation to close all small units because they are 'unsafe' was just not supported by fact and we must not act on the report as it represents one professions needs over the wishes of many mothers.

During question time Mr. Rosen made an interesting plea. He said not to blame him for the conclusions in his report. Anaesthetists came when called, and thus only wanted to find a reasonable situation in which to work. We are NOT to get the impression that anaesthetists want more work - they have plenty.

This statement made me very unhappy. Small GP units are being closed down all over the country. Dodgy financial arguments and phoney statements about safety are used to do it. Mr Rosen has supplied the opposition with yet another paper to prove the 'danger' of small GP units yet, in a way, wants us to believe he did so unintentionally.

I hope he will now take time to rethink and rewrite some of his conclusions in the light of new evidence about pain and its relief to the labouring woman. This report has helped to destroy a very basic and important option for women and his outspoken concerns for her and her discomfort should force him to produce an addendum.

Sandar Warshal.

Copies of "How to Oppose a GP Unit Closure" are available from Sandar (£2.80 inc. p&p)

CONFERENCE

OBSTETRICS & GP MATERNITY UNITS- RCGP National Symposium Birmingham 28th February & 1st March 1989

This two day symposium brought together a diminishing band of GPs involved in intrapartum care. That they are diminishing is without doubt. Speaker after speaker reviewed the statistics and told the tales of difficulties and closures.

Dr. Michael Bull in his opening introduction currently has 15% of his mothers under his care, previously this was 66%. Rona Campbell noted the decline of GP unit births from 15.4% in 1970 to 2% today, and the drop in GPs undertaking intrapartum care from 400,000 in 1963 to 100,000 in 1985. (75%). Consultant David Pickerell recorded the 60 year slide into consultant care from an 85% home birth figure for 1924 to a 94% hospital confinement in 1985.

That this will continue to decline is also without doubt, for there was a general feeling of wolves without the circle, watching and waiting - for the strength to attack, or a weakness to be exploited. Several GPs present were there in hope of support for their units currently under attack - but there was little comfort for them in the short term.

In spite of the above, it was not all doom and gloom, and what was to follow made the meeting worthwhile. Too late for many, but better late than never, the GPs made their decision to form an independent GP obstetric association to fight for the retention of community based care. If the enthusiasm and commitment of those present can be relied on this will happen. There were some fascinating (and some disturbing) descriptions of individual units and practises, and some thought provoking comments and conclusions.

The one consultant braving the 'lions den' to his credit produced a paper which illustrated with frightening clarity the biggest problem of integrated GP units. THE BOOKING POLICY. David Pickerell put up on screen the criteria for GP bookings at one hospital - Birmingham. This gave a series of 'scores' on a sliding scale which are awarded for risk. e.g. primigravida - (8) 2nd baby (1) breech - (10) previous pph. etc. These are not the actual figures because I not only had no time to write them down, (there were what appeared to be about 30) but because it was irrelevant. The criteria for a booking in the GP unit meant only those scoring 2 OR LESS were deemed suitable! A virtual impossibility.

Dr. Chandler who entitled his contribution 'A Peculiar Practise' opened with an unbelievable set of statistics. At his GP unit he has NO transfers or referrals, and accepts virtually all mothers for delivery including twins, breech, and VBAC. He gave it away when he revealed he also did his own forceps and caesareans.

His GP unit is integrated in what would appear to be a fairly unique way. He uses the same beds as the hospital, and has direct access to all the facilities including the consultant anaeshetist, paediatrician and obstetricians. He calls them in when he needs them, and in reality uses consultants as CONSULTANTS. The degree of midwifery involvement he encourages includes forceps lift out. It was an interesting item and although it left me feeling uneasy, it did illustrate a good example of complete continuity of care, something the consultant units who usually take his sort of cases could copy.

The difficulties of continuing GP deliveries after closure of isolated units was illustrated by one GP who told me that if his unit is closed he will cease practising, because the distance to the DGH is too far and his partners cannot cover.

The question of safety and economics was raised throughout the two days. It was accepted that there were no true grounds for closure on either basis.

The need to maintain a viable unit depended upon several things. Too stringent a booking policy would ultimately put all mothers into consultant care. There were those who believed it was vital that primigravidas were accepted, and that transfer rates were examined. There was disagreement among GPs about the numbers of deliveries needed to maintain skills. Dr. Bull felt that GP confidence was eroded by a small caseload, and there was a greater transfer of patients where less deliveries were undertaken. Should intrapartum care therefore be concentrated into a few GPs hands, or encourage all GPs to participate. Some units have 70% GP attendance at deliveries and it was felt that if skills were maintained in this way this would slow down transfers.

The decline of GPs in obstetric care was also mirrored in the consultant units. There was now a worrying shortage of registrars in some hospitals. There was a need to rethink the whole question of the education and training of doctors.

Learning in the hospital environment with only abnormal deliveries frightens the future GPs. (I think it was Dr. Noble from Scotland who suggested that all 'twitchy' GPs are sent to Africa for a while. It had worked with one of his partners!) Luke Zander said there was a need to understand what creates this sort of attitude that is endemic in obstetricians, and the growing number of new doctors, of birth being a dangerous process. Luke likened it to an orthopaedic surgeon at the bottom of a ski slope. He soon begins to associate skiing with broken limbs.

It was left to Luke Zander to point the way forward and offer action as well as words. The GP obstetrician IS a threatened species. The arguments are not about safety and economics, but about power politics. There was a need to understand the politics of change, and find ways as a group to develop strategies.

As with all conferences of this nature, it was the converted talking to the converted, But it was hopeful. If these GPs can get their act together, and form an association powerful enough to influence, they might just be the one catalyst for change we need.

Hana Blackmore.

In Support of GP Maternity Units

Dr. Gavin Young

In 1973 in the United Kingdom 12.8% of births took place in isolated GP Units. By 1984 the figure was 2.9%. The present figure is almost certainly lower as several units have closed in the past four years and more are threatened with closure this year. Why is this happening and what if anything should be done to prevent further closures?

HISTORICAL VIEW

Care during pregnancy and delivery used to be a cornerstone of general practise in Britain. Successive reports to the government have recommended that delivery should take place in large hospitals run by obstetric consultants e.g. Cranbrook Report of 1959 and Peel Report of 1970. (1) "We think that sufficient facilities should be provided to allow for 100% hospital delivery. The greater safety of hospital confinement for mother and child justifies this objective".

GP obstetrics continues within consultant units either "integrated" within the main unit or "attached" to it but deliveries in such units have not increased as much as the decrease has been in isolated units. Campbell and Macfarlane in "Where to be born" (2) provide a very detailed study of the changes in place of birth over the past century.

THE PRESENT

About one woman in eight now delivers under GP care. Less than one woman in thirty delivers in an isolated unit. I shall largely confine myself to describing isolated units, as by and large, GP care in integrated and attached units is not under threat. Some of the evidence which I will use relating to GP care has been gained from studies of integrated and attached units. Such units are not entirely comparable as transfer of a woman in labour will involve moving only within a hospital, if that. Transfer from an isolated unit may involve an ambulance journey of many miles. Marsh (3) has shown a greater commitment to their work by GPs working in isolated units perhaps because of the responsibility. I do not discuss home delivery mainly because health authorities have not yet discussed closing the homes of women intent on home delivery. One crucial point to bear in mind before any discussion on place of birth is that though units are referred to as "GP" or "Consultant" it is, and should be, MIDWIVES who provide overall care in labour and deliver babies. Any difference in style and outcome may have much more to do with differences in midwife behaviour.

SAFETY

Until recent years the major "reason" for closing isolated units is that they have been considered unsafe. All through this century maternity mortality and perinatal mortality rates have fallen at the same time as more women have delivered under consultant care. There are though many reasons for believing the two events are NOT - as it is usually assumed -causally related. Rates fell faster in the Netherlands which had a much lesser switch to consultant deliveries. Rates fell more in years when hospitalisation increased less. For further reasons see Macfarlane and Campbell (2). Nonetheless even someone as informed - and influential - as Dame Alison Munro (4), has falsely assumed that hospital delivery was the cause of the decline in perinatal mortality.

If there is not evidence to support an increase in consultant care, is there evidence in the opposite direction?

METHODOLOGICAL PROBLEMS

How do we measure better obstetric care? The best measures are maternal and perinatal mortality. However, thankfully, these are now very low at 0.07 per 1000 births and 8.9 per 1000 births respectively in England and Wales in 1987 (OPCS figures). The bulk of perinatal mortality is made up by pre-term births and congenital malformations. The first group would not deliver under GP care and the second group are hardly influenced by place of delivery. It has now become virtually impossible to run a trial to show a significant difference, even in perinatal mortality, with different methods of care. Of particular relevance here is Lilfords (5) calculation that over 700,000 pregnancies would be needed to show a 20% difference in perinatal mortality between "low risk" women delivered at home as compared with hospital. Even then there is only an 80% chance of showing this difference to be significant statistically (5% level). It is highly unlikely such a trial can now take place in the United Kingdom. What then can we do to get evidence?

Previous figures unfortunately were not gained from controlled studies. Consultant units take "high risk" women. Home births included unplanned home deliveries often in "high risk" women with concealed pregnancies and no antenatal care. Attempts have been made by Tew to compare like with like by looking at antenatal factors and giving "labour prediction scores".

IS GP CARE LESS SAFE?

When Tew (6) examined the results of the "British Births 1970" survey she found that GP delivery was safer at all levels except VERY high risk deliveries which fared better in consultant units. This means that certain women may be put at INCREASED risk by delivery in a consultant unit: the lower

their predicted risk for delivery the more their outcome is improved by GP care. This possibility has seemed to some so improbable they have chosen to ignore it. The Department of Health and Social Security in particular has repeatedly turned a blind eye to evidence which contradicts their scheme for increasing consultant care.

Descriptive studies not attempting to compare care directly have shown that GP care can achieve acceptable levels of perinatal mortality. Cavanagh's nationwide survey (7) of isolated units in 1982 produced a perinatal mortality rate of 5.2. My own survey of the isolated unit at Penrith (8) (1980-84) gave a rate of 4.7. Garrett et al (9) studied the Keynsham unit (1978-85) and found a perinatal mortality rate of 1.5. These figures included women transferred in labour.

Could it really be that delivery in certain women, without consultant care, could be safer? Tew wondered whether methods of care in consultant units might intensify risk. This possibility has been more fully discussed by Brody (10) who suggests that by treating every pregnancy as high risk, i.e. as if the worst possible outcome could occur, it may become more likely that the worst possible outcome will actually occur. This is the "maximin strategy" and needs further consideration.

OTHER FEATURES OF CARE

If one acted to avoid the worst outcome i.e. maternal death at the present time, only one woman in over 14,000 could benefit from the change in policy. Policy to reduce perinatal mortality could benefit less than one pregnancy in 100. Such results might be considered worthwhile if

(a) Such a policy achieved its aim.
(b) The policy had no ill effect

Unfortunately there IS a balance sheet. For example Caesarian section has been increasingly used to reduce perinatal mortality. The rate in England and Wales in 1987 was 10.6%. This results in some maternal morbidity (and very occasional maternal mortality).

Perhaps it is time to concentrate on the effect of different kinds of care in the 989 mothers out of 1000 whose babies survive. We can examine levels of intervention and interference. Klein et al (11) found less induction and use of forceps. Lowe et al (12) found less intravenous infusions and less monitoring under GP care. Other unexamined but obvious advantages of GP care are less travelling, lower number of different attendants in pregnancy and labour. Taylor (13) has examined consumer preference and found women prefered GP care. Mothers "wanted personalised, small-scale care with continuity and accessibility". The number of women, in her survey, feeling depressed postnatally was more than double under consultant care. Taylor too touches on the "maximin" stategy: "Policies formulated for the minority who experience problems might adversely affect the majority". Certainly closing GP units in Berkshire led directly to "hard shoulder deliveries on the M4".

It may be that differences in methods of care are effected primarily by the behaviour of the midwife. Such a possibility is worth studying. Could it be that a midwife who rarely sees an abnormal delivery acts in a different way to one on a unit with high risk deliveries? Might she be more confident of a normal outcome and might this feeling affect the labouring woman? Calm support in labour is considered of paramount importance by women giving birth.

If there is evidence that GP units may be safe (perhaps safer) for properly selected women and if women prefer them, why are units still being closed?

NATURE OF EVIDENCE

Macfarlane and Campbell end their thorough account with the depressing comment "perhaps the most persistent and striking feature of the debate about where to be born, however, is the way policy has been formed with very little reference to the evidence". Evidence to the most recent committees set up by Parliament has been in the form of professional OPINION and not scientific evidence e.g. the Royal College of Midwives was asked in the Short Report (14) if small GP hospitals were dangerous and replied "Yes, indeed they are". This opinion was founded on no facts whatsoever but was used as evidence. (Happily the Royal College of Midwives now supports GP units, realising their safety.) More recently, the Lothian Health Board when pressed by AIMS to produce evidence to support closure of Elsie Inglis Hospital listed "advice" (sic) from obstetricians. Such advice may be relevant and well-intentioned but it is OPINION only, not FACT, and needs to be seen as such. The answer government gets is decided by whose "advice" government chooses to seek.

A recent example of very one-sided advice was the Association of Anaesthetists' report (15) recommending closure of small maternity units. The committee included only one obstetrician (who worked in a very large unit), no GP, no midwife and no representative of the patients. The Association recommended closure of very small units even though only a very small number of women starting labour in such units will need an anaesthetist. The anaesthetists mention safety but present NO evidence that closing small units could improve safety. The other reason for recommending closure is that scarce resources should be centralised. The economics of small units need examining.

COSTS

Economy is now used as the major argument for closing small units. It is far from clear whether this argument stands up. Gray and Steele (16) suggest GP units may be MUCH cheaper and that "If savings are to be sought in the maternity sector, it is probably to the specialist units rather than GP units that we must look". Closing a unit gives immediate savings - an attractive reason for health authorities forced to be so concerned with annual budgets. Longer term expenses after closure are less easily noticed:

(a) Increasing transport costs (both to the health authority and the patient);
(b) Increasing medical costs if more hospital staff are needed (GPs exist whatever and are paid only £29 per delivery);
(c) Increasing midwifery costs. (These would rise even more if home births increased, which they might, because pay grades have made community midwives relatively expensive).

Given the small number of deliveries in isolated units, only a small proportion of the overall budget will be saved.

GP units are vulnerable and make easy scapegoats. The Association of Anaesthetists used small units as a "resource" scapegoat as well as a safety scapegoat. If the Caesarian section rate fell by just 1% it would have a far greater impact on anaesthetic requirements than closing ALL GP units, but the Association of Anaesthetists chose not to question obstetricians' actions. Turner et al (17) showed that O'Driscoll's active management of nulliparous labour reduced the caesarean section rate at Northwick Park from 15% to 10.8% in one year. That the Caesarean section rate in the National Maternity Hospital in Dublin is under 5% which has good perinatal mortality figures should interest the anaesthetists far more than the existence of small obstetric units.

WHAT HAPPENS NEXT?

If GP units are closed, very small amounts of money may be saved in the short term which will scarcely be noticed. Their loss will certainly be noticed - most importantly by the women who give birth in them, who appear to prefer them and who, the evidence shows, may be at less risk delivering in them. The evidence indicates that such women are more likely to deliver feeling that they have given birth, not BEEN delivered an "achievement", not a "being done to".

If GP units are closed, more women may opt for home births. When they do so they will be attended by midwives with little experience of delivery away from technical back-up and by GPs with probably no recent experience of care during delivery. Women near attached and integrated units will still be able to have GP care. Women in rural areas will be confronted with long journeys, unfamiliar faces and probably less support. Such factors in themselves may affect the outcome of childbirth. (18) Closing such units may worsen the standards of care, a strange anomoly when the government is trying to offer the consumer a greater choice in health care.

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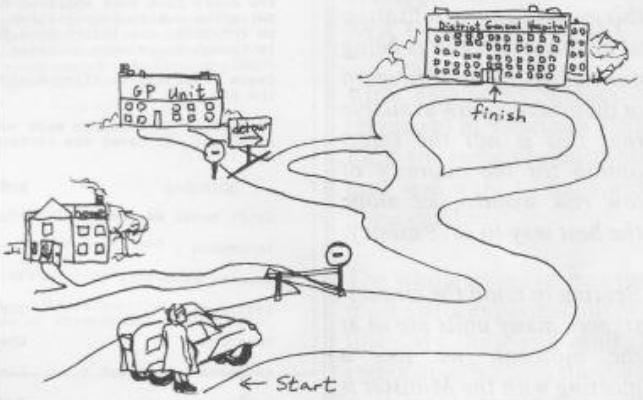
TOWARDS A ONE-WAY SYSTEM

NANCY STEWART



For a society whose guiding principle is now described as the wisdom of market forces, of demand guaranteeing supply, the dwindling choices of where a woman may have her baby seems a contradiction. Businesses, even schools and colleges, are being urged to diversify to offer a broad range of services to attract the customers. But the pregnant woman is a captive client: in many areas now she goes to the one available mega-hospital, and consumer choice never enters the equation.

Of course, her presumed lack of interest in any other option may be given as evidence that a centralised consultant service is what she really wants. Where they still exist, GP units are often operating at a low bed-occupancy rate - which also makes them look rather expensive per patient. And the community maternity services can manage with reduced staffing levels - look how few home births there are these days.

What these arguments ignore are the reasons behind the small numbers of women making use of these services. The first hurdle on the road to any other than the consultant hospital is ignorance. Few women know that home birth is an option, or that they can choose to have their babies in small local GP units. And, lacking the advertising ethos of a market economy, GPs don't hurry to inform women booking for antenatal care of the options that may exist, and the advantages and disadvantages of each.

If a woman is lucky enough to discover that she has a choice, she then usually faces active discouragement of any other option than the large hospital. Having withstood that, she is then prey to protocols narrowly defining the 'normal' pregnancy which is allowed to continue with the GP/midwifery care. If anything remotely questionable arises, she is swiftly referred to the hospital, and this is in most cases a one-way traffic - having been checked and found to be normal, she is not then referred back out of consultant care. With this sort of funnelling, it is not surprising that centralised hospital services have the most births.

Why does this happen? Is it a rational way to plan the maternity services? Obstetricians have long argued that consultant care in large hospitals is the safest for mothers and babies, but the research that has been conducted has discredited this contention. Indeed, home birth, and a birth in small GP units, has a much better safety record than consultant deliveries. Can it then be economic? is it cheaper to run things in this way? the answer again is no, for consultant salaries are higher than GPs and midwives, and obstetric technology is not cheap. There are also hidden costs such as the extra transportation for women from outlying areas into a central clinic. The point is, though, that in the short term - for balancing a budget this year - a hard-pressed health authority may save money by closing a hospital. In the long term costs are higher, but planners don't necessarily have to consider those costs now (just as "market forces" that set the prices for our consumer goods today don't have to consider the costs to us all in the future of waste and pollution from the manufacturing and energy processes they involve).

The other hidden costs in the balance sheet are those that can't be quantified - the loss to women of human scale care, in their own communities. And the loss of their time and serenity as they travel to large impersonal hospitals, often with other children in tow.

Lack of cash for the health service, part of a policy of starvation of resources to encourage people to turn to the private sector if they want choice, has been coinciding very well with the obstetric profession's pulling in of the reins to centralise control of the process of having a baby. It is hypocrisy to claim that this process serves mothers and babies: it doesn't make economic sense, it doesn't make sense in terms of health, and it certainly doesn't give any choice to the "consumer".

Here and there outcries have stopped or slowed the process, but there have been many more casulties than successes. AIMS has produced suggestions for fighting the further restrictions of available services, and it is to be hoped that through pooling information and ideas the insidious decline of maternity care choices can be stopped. Coherent argument can expose the fallacies in the logic of closures, but only a more deeply rooted and widespread change in the assumptions on which maternity care is based will cause a real about-face.

Nancy Stewart

DEATH OF CHOICE

These written answers on GP Maternity Units were given to Michael Latham MP on February 23rd 1989. Michael Latham very kindly sent a copy of this reply to Beverly, and I replied on behalf of AIMS in March.

Dear Michael Latham,

.....I am appalled at the inadequacy of the reply. The statistical information that appears to be available centrally is so inaccurate that I fail to see how it is possible for the Department to be even remotely aware of the prevailing situation. The escalating closure of GP maternity facilities would appear to be going largely unnoticed by everyone except those involved locally.

In particular I am very concerned that the Department does not appear to keep accurate records, or even be informed of changes in services. I have copies of other Government replies which list units not on your current list, and units left off the others, and even worse units which do not appear on any lists. In reality there would appear to be little correlation between replies.

What makes me personally very angry is that I was involved in a campaign to keep our GP unit in 1982, finally lost in 1983. This unit (Congleton) is not on your list nor is its neighbour Knutsford, closed in 1981. What is even worse is that I was one of a delegation that came to Parliament with our MP Nicholas Winterton to argue our case - with one Kenneth Clarke, then Minister for Health. If this unit can so easily disappear from ministerial records together with its 11,000 signature petition presented to Parliament, how many more have slipped quietly out of existance, unrecorded, unnoticed, and uncared for?

AIMS is very disturbed by this reply and feel there is an urgent need for the matter to be brought to the attention of the Secretary of State, and members of Parliament. We are most concerned that this escalating centralisation of maternity service is being pursued with a total disregard of the evidence now available that this is not the safest option for the majority of low risk women, let alone the best way to save money.

Bearing in mind the circumstances many units are in at the moment, we feel a meeting with the Minister is crucial. We would be very grateful if you could advise us on the best way to pursue this, for we are in grave danger of losing all choice in maternity care in this country, and it would appear that the Government either knows nothing about the problem, or it couldn't care less.

Yours sincerely,
Hana Blackmore
AIMS

These written replies raised a number of questions and thoughts in my mind.

First, the need to confirm the magnitude of the inaccuracies. Would anyone who also finds their unit is not listed, or know the information in the reply is inaccurate please contact me as soon as possible. AIMS can then pass this information on to the Minister etc.

THE INFORMATION REQUESTED IS NOT AVAILABLE CENTRALLY

Thursday 23 February 1989
Written Answer

PQ 1910/1988/89
PQ 1912/1988/89
Han Ref Vol
Col

G.P. MATERNITY UNITS.

W21 **Mr Michael Latham** (Rutland and Melton): To ask the Secretary of State for Health, whether he will set out in tabular form, identifying the unit in each case: (a) how many isolated general practitioner maternity units have been closed in each year since 1979 and (b) how many integrated general practitioner maternity units have been closed over each period.

W22 **Mr Michael Latham** (Rutland and Melton): To ask the Secretary of State for Health, whether he will set out in tabular form, identifying the unit in each case, the number of: (a) isolated and (b) integrated general practitioner maternity units where a formal decision has been taken and published to close the unit, indicating where appropriate when the decision by Ministers is awaited following a formal objection by the Community Health Council.

MR ROGER FREEMAN

The table lists GP maternity units which we are aware have been approved for partial or total closure following public consultation. The period covered is from 1979 to end 1987, the latest date for which details are available, (although there were no cases in 1987).

Cases currently awaiting Ministerial decision are listed at the end.

"Isolated" is taken to mean not part of a District General Hospital. All cases are isolated unless stated.

Hospital	Area/District	Type	Year
Croft Baker Maternity	Humberside	T	1979
Immingham	..	..	..
Townend Maternity *	..	..	..
Nightingale	Derbyshire	..	..
Davenham	Cheshire	..	..
Skegness & District *	Lincolnshire	P	1981
Urmston Cottage	Trafford	T	..
Harpenden Memorial	NW Herts	P	1982
Ashgate Maternity Home	N Derbyshire	T	1983
Chase Hospital	Mid Staffs	P	..
Wendover Maternity Unit	Southmead	T	..
Alexandra Maternity Hosp	Plymouth	..	..
Woodgates Maternity Home *	E Yorkshire	T	1984
Darley Hall MAternity	N Derbyshire	..	..
Corbar Hall Maternity	..	..	..
Westbury Maternity	Milton Keynes	..	..
Westminster Memorial *	Wiltshire	P	..
Wellington Maternity Home	Somerset	T	..
Leek Memorial	N Staffs	..	..
Queen Mary Maternity Hse	S Derbyshire	..	1986
Phyllis Memorial Home	E Suffolk	..	..
Market Harborough	Leicestershire	P	..
Rutland Memorial	..	..	..
St Mary's Melton Mowbray	..	..	..
Ashby de la Zouch	..	..	..
Isebrook	Kettering	..	..
Ashcombe Hse	Bristol & Weston	T	..
Rossendale General #	Burnley, Pendle & Rossendale	P	..

* Ministerial decision

\# Integrated unit

NB The Leek Memorial Hospital is, in fact, still open but is scheduled to close this year.

Cases currently with Ministers

Partial closures at Sandleford, Wokingham and Townlands Hospitals - all West Berkshire.

St Paul's Maternity Unit, Hemel Hempstead Hosp, NW Herts.

DEATH OF CHOICE

Thursday 23 February 1989
Written Answer

PQ 1914/1988/89
Han Ref Vol
Col

G.P. MATERNITY UNITS

W23 Mr Michael Latham (Rutland and Melton): To ask the Secretary of State for Health, whether he will set out in tabular form, identifying the unit in each case, the number of: (a) isolated and (b) integrated general practitioner maternity units which are currently the subject of public consultation on closure.

MR ROGER FREEMAN

The information requested is not available centrally.

Thursday 23 February 1989
Written Answer

PQ 1915/1988/89
Han Ref Vol
Col

G.P. MATERNITY UNITS

W24 Mr Michael Latham (Rutland and Melton): To ask the Secretary of State for Health, whether he will list by name and date since 1979: (a) the isolated and (b) the integrated general practitioner rural maternity units where Ministers have rejected a closure proposal, following an adverse report from the Community Health Council; and which of these units remain open.

MR ROGER FREEMAN

We are aware of two such cases.

In 1984 proposals to close GP maternity beds at :-

a) Amersham General Hosp (integrated unit) and

b) Crowborough War Memorial Hospital (isolated unit)

were rejected by Ministers. The beds at Amersham are currently closed for redecoration : those at Crowborough remain open.

With regard to the content of the replies, I find it very disturbing that only 4 units on the list actually got to the Minister - which implies these were the ONLY closures that the Community Health Councils opposed. What happened to the rest?

Did the CHCs support the closures? Did they find it impossible to put forward the alternative proposals required under the closure 'rules'? Were they 'persuaded' by Health Authorities or frightened by obstetric horror stories to drop their opposition? AIMS would be very interested to hear from them too.....

I find the final response that ONLY TWO UNITS IN TEN YEARS have been saved by Ministers - to be one of the most chilling statistics we have received. How do we fight closures when faced by such demoralising facts? The further information that the Amersham beds are "closed for redecoration" makes me wonder for how long this unit will continue to be 'saved'.

My final thought takes me back to the title of this article. The inaccuracies in the written replies are understandable (but not forgivable) if the Department does not request the information, or Districts and Regions fail to inform the Department of closures and changes in service. But what I totally fail to comprehend is how the information which MUST be available centrally -those cases where Ministers have rejected closure decisions - is not considered accurate by the department.

The reply states that in the case of the two proposals rejected by Ministers they were...."aware of two such cases".... Only aware!.... DON'T THEY KNOW FOR CERTAIN???

Hana Blackmore

YOU WRITE

GOOLE GP MATERNITY UNIT

After having my first child (Hannah) in February 1985 I did for some considerable time not want to have any more children.

The whole 'process' was the most awful experience of my life. My husband and I complained but with standard outcome - a complete cover-up as well as me being made out to be 'a liar'. I had been reduced to a very low mental state by the disgusting treatment I was given, but more importantly the appalling way the complaint was 'dealt with'. It was even suggested that I must be suffering from postnatal depression. Even my own doctor refused to discuss the matter. I therefore turned to AIMS.

I found reading the journals very comforting - to know that there were other people who had been treated as badly as I had and who felt the same way I did. I also gained much information from AIMS, so in the summer of 1987 we decided to embark upon another pregnancy.

This time I chose my attendants and booked to go to my local GP unit at Goole. (I had asked to go there to have my first baby but was refused). I was this time not under 'the care' of any consultant, but went to my doctor for antenatal care as well as home visits from two of the Community Midwives who work from Goole, (not attached to my GP). Whichever was on duty at the time of my labour was to deliver my baby.

On June 9th 1988 my 8lb 14½oz son was born after only 2 hours in the unit and a few whiffs of gas and air, with my husband and our doctor present. I stayed for five lovely days and learnt this time how to feed and look after my baby properly.

David is now 9 months old, has been completely breastfed (I still feed him at night) and is in the 90th centile.

What more need I say but to thank AIMS for giving me the information and the strength to fight for what I wanted, as I am quite sure without it I would have had a repeat performance.

The closure of Goole Maternity Unit has been suggested due to under usage. If more women in this area would assert themselves and choose where THEY want to give birth instead of allowing themselves to be automatically channelled to one of the surrounding 'sausage factories' the future of this unit would not be threatened.

Clare McGurk,
8 Loftsome Way
Howden, Goole
N. Humberside

STOP PRESS: GOOLE MATERNITY UNIT CLOSED on Monday 10th April for '6 weeks due to staff shortages' Offers by local midwives to cancel holidays to keep unit open rejected out of hand

YOU WRITE

GP UNITS IN SHROPSHIRE WIN TEMPORARY REPRIEVE

A temporary victory at least has been won by a joint effort of Shropshire midwives, doctors, AIMS and NCT members against plans to close one of the County's GP maternity units. While three-quarters of Shropshire's babies are born in the consultant unit at Shrewsbury, the remainder are born in GP units around the county. This may be more significant for the quality of care than the numerical proportion would imply, because all the midwives in the county rotate among the various units, and midwifery administrators feel that this enables midwives to bring their understanding and experience of normal low-tech birth back from the GP units to the central consultant unit, influencing care for all women.

In a plan to balance the health authority budget by closing several small hospitals, the Oswestry maternity unit was under threat. But as a result of combined pressure against the closure, the local maternity service has been saved from the chop.

Miss R.O. Craven, Director of Maternity Services for the Shropshire Health Authority, has written to AIMS:

Dear Ms. Stewart

"Further to our correspondence in the spring of this year, I write with the good news that the Maternity Services are going to be continued in the Owestry area. The outcome of the decision was very much in the balance, and undoubtedly the support we were given was a very important factor in achieving this successful outcome.

As you may have read in the paper, the Oswestry and District Hospital sadly is to close, but a promise has been made for some of the services it provides to be resited at the Robert Jones and Agnes Hunt Hospital, a short distance away.

A very reasonable sum of money has been allocated for the conversion of one of the wards for Maternity use. I visited the ward at the end of last week and I am happy that we will be able to convert the area to a to very satisfactory Maternity Unit with a clinic area adjacent to the Labour Ward and Postnatal Ward areas.

The provision of the Maternity Unit is a temporary reprieve, but it is an important one as it allows us to continue to fight for the General Practitioner Units to be part of the future of the Maternity Services as a whole in the County. As you are aware, discussions are now being held concerning a new Maternity Unit planned for Telford in phase 11 of the Telford District General Hospital. "Rationalisation of the Maternity Services" will be considered and our pattern of service, as given now, will have to be strongly defended; have your sharpened pencils at the ready!"
30.11.88

Nancy Stewart

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BOOKS

MIDIRS DIRECTORY OF MATERNITY ORGANISATIONS 1989, 3rd Edition

MIDIRS has completely updated and revised their directory. All organisations included were contacted and the information was correct at the time of going to press in March 1989.

The comprehensive directory lists over 170 statutory, voluntary, self-help and support groups of interest to pregnant women and their babies and the people who care for them. (There is a subject index as well as the alphabetical group lists which is particularly helpful.)

The directory is now published only in this format and is no longer included as a section in the MIDIRS Information Packs. Copies can be ordered from MIDIRS for £2.95 each (p&p included).

See new address from end of May 1989 in Noticeboard.

YOUR BODY, YOUR BABY, YOUR LIFE.

Angela Phillips with Nicky Leap & Barbara Jacobs. *Pandora Press Nov. 1988 211pp £4.95*

This book is the second reprint of the original 1983 edition (reviewed in the AIMS Journal for Summer 1984) but unfortunately there is no indication of how extensively it has been revised to cover the considerable developments of the past five years. Some figures have been updated but the list of 'Useful Organisations' carries a number of contact addresses, now altered, which an alert editor should have checked. Members of AIMS will be amazed to read that according to this book, the journal comes out six times a year! The booklist, too, is out of date in both content and prices quoted.

In the space of 200 pages Angela Phillips covers every conceivable topic which a pregnant woman could want to know about: from herpes to day nurseries and from terry nappies to birth positions. Inevitably in such a short space the treatment of many subjects is superficial but there is a great deal of commonsense advice based on personal experience. Much of the text reads like an article in a woman's magazine: short paragraphs, clear headings, coy euphemisms ('the other stuff' for faeces) and an almost complete absence of research references. Frequent quotations from women on how THEY felt at a particular juncture break up the rather breathless rate at which information is dished out.

Disappointingly the author's approach to her subject is a lot less radical than the title of the book would suggest. Her section on home birth puts the onus on the woman to find a doctor to attend her and throughout the book there is no indication of what a woman's RIGHTS in maternity care might be, she

is seen rather as a passive consumer of whatever might be available in her area. Reassurance is the order of the day: for example, on ultrasound we are told 'this seems to be a pretty safe way of obtaining quite a lot of useful information'.

Angela Phillips' attitude is summed up by her sentence 'This may be your first baby and the most important event in your life, but to them (the hospital staff) it is a job and you can help make it a pleasurable one'. How can the author compare a woman's experience of childbirth - which she is unlikely to have more than 3 or 4 times in her lifetime - with the transitory job satisfaction of a doctor or midwife who can expect to attend hundreds of births in the course of their working lives!

In the past ten years women have become much more aware of their needs and rights as human beings and as consumers of the maternity services. This book fails to reflect these changes and so perpetuates the ethos of the paternalistic system which pervades so much of the health service.
Elizabeth Key

CAESARIANS: An explanation and preparation.

Elliot Philipp
Sidgwick & Jackson. £8.95

This book, apparently aimed at mothers, is clear, easy to read and gives comprehensive coverage of the reasons a caesarean section may be performed, how this is done (in great anatomical detail) and the physical and psychological effects of this major operation.

The author stresses that he believes that women should make informed decisions about the care they receive: a pity then that some of his information is so biased.

For example, routine foetal heart monitoring during labour is assumed: the reader is informed that 'in the past (!) the midwife placed a stethoscope on the mother's abdomen'. Apparently it does not occur to Mr. Philipp that a woman may wish to exercise her right to refuse electronic monitoring: 'Most women are reassured by the monitor and feel pleased that the wellbeing of their babies is being charted. Many partners are intrigued by the monitor and observe it (not, of course their partner) carefully.'

Needless to say, improved perinatal mortality and morbidity rates are ascribed to 'technology', including foetal heart monitoring, despite the distinct lack of evidence to support this hypothesis.

Mr. Philipp devotes careful discussions to the indications for a caesarean section: I was therefore surprised to find that a breech presentation in a woman over 35 expecting her first is an 'absolute indication'.

Worst of all is the astoundingly insulting scenario of an imaginary failed home birth which ends with an emergency caesarean section being performed.

Depressing stuff from a man described as "one of Britain's most eminent obstetricians". I notice that he includes SILENT KNIFE by Nancy Weiner Cohen and Lois J. Estner in the further reading list. Why not forget Mr. Philipp, save yourself £8.95 and go and buy SILENT KNIFE instead.
Kate Ling

(Silent Knife is published by Bergin & Garvey. Available from Changes bookshop, London. Also available from AIMS library, contact Nadine Edwards.)

THE ART OF BREASTFEEDING

La Leche League International. *(3rd Edition - 1958, '63, '88) Published by Angus & Robertson. £5.95*

Described on the front cover as "the complete guide for the nursing mother", this awesome manual contains a mine of information for breastfeeding mothers, La Leche League now has over 4,000 groups in 44 countries. This latest edition has been revised and adapted by La Leche League for readers in Great Britain, Ireland and Australasia. There are forewards by Dr. Penny Stanway, Michael Odent, and Dr. Ruth Schell. It is written by the League's founder members, 7 women who breastfed 24 babies between them.

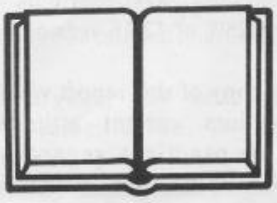
"Its principles are simple, its truth obvious", says Ruth Schell and the book indeed provides a whole philosophy for mothering from pregnancy to bringing up a child 'forever'. It it is a celebration of feminine values - the effects of which enrich not only the individual but society as a whole.

As a breastfeeding mother myself I found the contents helpful, detailed and wide-ranging. I wholeheartedly agreed with the advice to go at baby's own pace and not force things on her for which she was not ready. It gave me solid backing for nursing my baby whenever she wanted to, and the courage to keep her in my bed when she woke at night.

All in all I found it hard to fault the book and have only a couple of gripes:- I was intimidated by the advice to postpone going back to work as long as possible, especially as my maternity leave comes to an end soon; and I was disappointed to find no mention of alternative medicine, which I have found invaluable in childbirth and for my little ones' ailments.

There are lovely photographs of babies happily breastfeeding and cuddling. The tone of the book suggests that parenting is satisfying and fun. There is a definite bias towards natural childbirth, and a questioning of current medical practices. The appendices contain a booklist and LLL information sheets, Organisations of interest to parents (including AIMS), and a list of manufacturers and suppliers.

So it is hurrah for La Leche League and their new book. Every mother shoould have one.
Liz Hopkins



IN BRIEF

ECTOPIC PREGNANCY ON THE INCREASE

The incidence of ectopic pregnancy is increasing, only in part due to better diagnosis. A study in Aberdeen (BMJ Obs & Gyn 1988;95:740-7) reports a 3 fold increase since 1970 to 6.4 pregnancies. A large number of previously sterilized women had ectopic pregnancies: 0.35 per 1,000 sterilized women.
BMJ Vol. 297 24th Sept. 1988

ROOM FOR PARENTS CAMPAIGN

This is the title of the third report from Caring for Children in the Health Services, a group consisting of NAWCH, the British Paediatric Association, the Royal College of Nursing and the National Association of Health Authorities. Its major recommendation is that beds should be made available to parents of child patients in the following proportions:

for 100% of under-fives
for 75% of 5-7 year olds
for 50% of 8-11 year olds
for 25% of 12-16 year olds

A copy of this report which outlines current attitudes and practices regarding parents in hospital with their children has been circulated to each health district.
NAWCH UPDATE Autumn 1988

SLEEPING POSITION OF BABIES

Prof. John Emery, Emeritus Professor of Paediatrics at Sheffield University and a father of seven, questions the idea that the position in which a baby sleeps can be a contributory factor in cot deaths. In hospitals babies sleep face down but at home this might not be advisable as attendance is not constant and soft mattresses or pillows might make it less safe. Prof. Emery suggests that babies should sleep on their sides so that their faces can easily be seen. Apparently the Chinese, who have a low rate of cot death, look at the sleeping babies face frequently.
The TIMES 6th Oct. 1988

FATHER'S ANTIGENS A MAJOR CAUSE OF MISCARRIAGE.

The Miscarriage Association Newsletter (Autumn 1988) carries a detailed article on recurrent miscarriage by Prof. Beard of St. Mary's Hospital Medical School in London who established a special clinic at the hospital in 1982 to deal with this problem. A trial was subsequently set up with the help of the Medical Research Council and when completed three years later it was established that a lack of recognition of the father's antigens was a major cause of miscarriage. 77% of women who were immunised with their husband's white blood cells had a successful pregnancy.

The Newsletter is available to members on subscription (£6 p.a.) from:
P.O. Box 24, Ossett, West Yorkshire WF5 9XG.

FATHERS AND POSTNATAL DEPRESSION

A report on the fourth international conference of the Marce Society by Victoria McKee described the current work of its president Prof. John Cox of Keele University. He is attempting to organize regular fathers' groups in his 'Parent & Baby' day hospital in Stoke-on-Trent which would replace the traditional 'Mother & Baby' clinics. He feels that fathers are as liable to suffer from post-natal depression as mothers: as he points out: "The hospital system makes fathers strangers. Women feel alienated enough during the hospital experience but fathers....are suddenly reduced to the part of visitors". He feels that if fathers can meet together to talk about their experiences they are less likely to develop emotional disturbances.
The TIMES 6th Oct. 1988

CATCHMENT AREA 'CATCH'

One of the best known centres for treating women with recurrent miscarriage is St. Mary's Hospital in London. However, in yet another example of dwindling access to health care, hospitals are getting much more rigid about catchment areas, so that only women in St. Mary's catchment area have access to that hospital.

However, for a payment of £450 to 'cover administrative and lab costs' women from outside the area can attend the miscarriage clinic.
WHRRIC NEWSLETTER Issue No. 1. June 1988

ISLE OF SKYE MATERNITY SERVICE

As a result of health service cuts on the Isle of Skye, there are only 2 maternity beds left. The island has a population of 8,300 and now has to depend on a flying squad from Inverness. At Broadfield Hospital, maternity beds had been cut from 2 to 1 and at Portree 3 beds had been taken away leaving a single bed. Mr. Kenneth Macmillan, NUPE's Area Officer for the Highlands and Islands revealed also that towns around Inverness had dramatically cut back on maternity beds. e.g. at Grantown-on-Spey maternity beds had been abolished due to lack of government funds.
SCOTSMAN April 22nd 1988

(Ed. Note any update on this item?)

DRUGS IN PREGNANCY

WHRRIC (Women's Health and Reproductive Rights Information Centre) Newsletter Issue No. 3 focuses on the use and misuse of prescription drugs including contraceptives, tranquillisers and HRT. An informative article by Lisa Saffron on drugs in pregnancy recommends caution over taking any kind of drug whilst pregnant, whether prescribed by a doctor, bought over the chemists counter or social drugs like tobacco and alcohol or alternative medicine treatments.

The absence of a single source of information on teratogenesis (i.e. damaging to the fetus) makes advising pregnant women difficult but Lisa Saffron concludes that one should only use a drug with very sound reasons for its use and to opt for drugs which have been used for many years in pregnancy without apparent ill effects.

Newsletter available on subscription only from: WHRRIC, 52 Featherstone street, London EC1 8RT.

HEALTH AUTHORITIES TO GET MATERNITY SERVICES MANUALS

The Office of Population Censuses and Surveys (OPCS) has developed a model questionnaire and survey manual for Health Authorities to use when testing consumer opinion about antenatal and postnatal services.

OPCS carried out a pilot survey in four health districts in 1987 for the Department of Health, questioning 1,800 pregnant women and 1,800 recent mothers. The package was developed from the results of this study.

An OPCS spokesman is reported as saying that "the complete package will give users practical advice on how to carry out and follow through their own consumer survey....the whole process is explained in the manual and HAs can adapt the questionnaires to suit their own local circumstances".
The HEALTH SERVICE JOURNAL 6th April 1989

Research

FASTING IN LABOUR

It is standard practise in many countries, including the UK to deny labouring women food and drink in the belief that, should the use of anaesthesia become necessary, the likelihood of maternal mortality and morbidity from pulmonary aspiration is reduced. However there has not been one documented case of maternal death or injury from aspiration in a woman who has been properly anaesthetised, whether or not she has eaten during labour. Most anaesthesiology experts agree that causes of maternal mortality and morbidity are poor anaesthesia technique and failure to comply with proper standards. Depriving the mother of foods and liquids during labour may actually increase the risk of maternal mortality and morbidity from acid aspiration.

A labouring woman may be burning 700-1100 calories an hour; there is a direct relationship between maternal blood glucose levels and fetal wellbeing. When glucose is not available for energy use the body draws on its fat supplies: the mother excretes ketones and as levels in her blood and tissues rise so do levels in the fetus, and blood Ph value can be decreased.

Intravenous glucose, administered to labouring women who become ketotic, carries risks of hypoatremia and subsequent tachypnea in the newborn and can cause haemodilution resulting in diminished capacity of the blood to carry oxygen to both mother and fetus. Other deleterious effects on the fetus resulting from intravenous glucose induced hyperglycemia are acidosis, increased carbon dioxide levels lactic acid levels and neonatal jaundice; it is potentially dangerous to the rapidly developing fetal brain and increases the danger of neonatal hypoglycemia which may reult in respiratory distress, cyanosis and seizures.

As an illustration, figures from the North Central Bronx Hospital in a socially deprived area of New York are given: for a six month period the normal practise of allowing women to eat lightly and drink throughout normal labour was suspended:

- The only case of aspiration occurred in a woman who had taken nil by mouth in 36 hours.
- use of chemicals to stimulate labour increased five fold.
- instrumental delivery increased by 35%
- caesarean section increased by 38%
- vaginal birth following a previous caesarean decreased by 37%
- the need for intensive care of the newborn increased by 69%

As a result of the deterioration in fetal and maternal wellbeing the practice of permitting labouring women to eat and drink was reinstated and outcomes returned to previous superior levels.

A study of Dutch midwifery services which allow eating and drinking also supports the total lack of evidence that fasting labouring women reduces risks of aspiration, and this paper recommends that such routine fasting should be abandoned.

(Paper presented at the International Confederation of Midwives 21st Congress in the Hague, August 1987, by Leslie Ludka, USA. MIDIRS Information Pack No. 7, April 1988)

SUPPLEMENTATION IN PREGNANCY

The pros and cons of iron and folate supplements during pregnancy are examined (lightly) in two papers in the BMJ's Controversies in Therapeutics. Supplements have been in widespread use since the 1950's, their introduction originating from the era of economic depression 'Welfare foods', and coincidently, the development of organised antenatal care.

That maternal stores of iron and tissue folate concentrations decrease during pregnancy is undisputed, but depletion does not necessarily equate with deficiency. Much iron is debited from the stores to increase red cell volume and becomes available for storage again 5-12 weeks postpartum. In a review of 17 controlled clinical trials (some with methodological inadequacies) Hemminki and Starfield found little or no obvious benefit from iron or vitamin (or both) supplementation in developed countries.

In arguing for selective supplementation, Bryan Hibbard points out that healthy eating campaigns

are rife in other fields of preventative medicine so why should not greater impetus be given to promoting good eating during pregnancy. Suggesting indications for supplementation he also points out that the patients understanding of their specific need is more likely to lead to better compliance in taking the supplements.

According to WHO criteria, anaemia is present in pregnancy when the haemoglobin concentration is less than 110g/1. A woman with anaemia is less able to withstand haemorrhage at delivery or during surgical intervention and studies show that women with haemoglobin concentrations less than 110g/1. more commonly experience fetal death, low birth weight and premature babies. Low oestriol values, which may indicate placental insufficiency are also associated. However all are associations, not cause and effect. Elsewhere in the paper arguing for universal supplementation, it is noted that women most at risk are those of poor socioeconomic circumstances and poor attendance at ante-natal clinics. In that case they might well be missed by universal supplementation anyway and would stand to gain most by individual assessment and nutrition counselling.

The cost of an efficient screening programme looms large in the argument for universal supplementation together with laboratory workload difficulties and follow-up of patients. (But all this was overcome to introduce ultrasound scanning wasn't it?)

(The Editorial Comment on the papers favours selective supplementation).

(Iron and folate supplements during pregnancy: Supplementation is valuable only in selected patients. Bryan M. Hibbard.
Iron and folate supplements during pregnancy: Supplementing everyone treats those at risk and is cost effective. Elizabeth Horn
BMJ V297 19.11.88)

EFFECT OF VEGAN DIET ON PREGNANCY

This study investigates the reproductive 'performance' of women living on The Farm, Tennessee, to assess claims that vegetarians and especially vegans, have an inadequate diet for pregnancy resulting in fetal growth retardation and low birth weight. It was found that this was not the case, and that The Farm diet - no meat or dairy products, no alcohol or cigarettes and only rarely coffee, protected women against pre-eclampsia. Out of 775 women (240 primigravidas) only one developed pre-eclampsia 1970-1984). In 1981 it was also found that although pre-pregnant weight of Farm women was 10lb less than that of the general US female, Farm women were slightly taller, weight gain during pregnancy was around 5lb more and the mean length of pregnancy was 39.8 weeks. Only 6% of pregnancies lasted less than 38 weeks. Average birth weight was 3,342.4 grammes (approx 7lb 6oz) and for each additional year a woman had become a vegan birth weight increased by 42 grams.

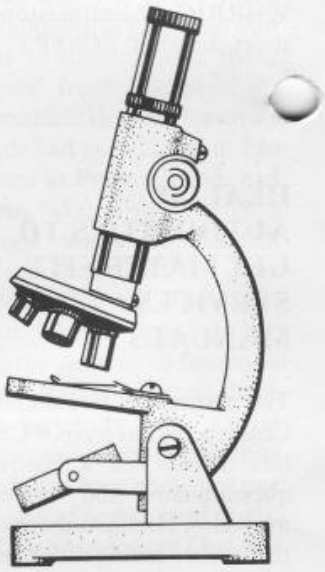
(Pre-eclampsia and Reproductive Performance in a Community of Vegans. J.P. Carter et al. Southern Medical Journal, Vol 80 No. 6, June 1987. MIDIRS Information Pack No. 9 December 1988)

MOTHER & BABY SURVEY 1988

This year more than 7,000 readers of 'Mother & Baby' replied to its annual survey on having a baby and many wrote detailed letters as well. The results show that the vast majority gave birth in hospital. Only 1% gave birth at home though 16% had considered this option and 5% had actually made a formal request for home confinement. Of these over half were put off by their GPs and 15% had medical complications which would have made a home birth inadvisable. As mother & Baby readers are more likely to be representative of pregnant women as a whole than are AIMS members this shows an amazing unfulfilled demand for home birth.

80% of births were in consultant units and only 13% in GP units or small cottage hospitals. GP units, unsurprisingly, came in for praise for their informal and caring atmosphere. In general the majority of mothers in the survey said they were satisfied with their hospital but this includes the third who complained about lack of freedom to move around in labour and almost a half would have liked encouragement to give birth in alternative positions.

Answers to questions about pain relief showed that half the mothers had pethidine. A fifth epidurals, three-fifths gas and air while 17% did without artificial pain relief altogether. Episiotomies were carried out on nearly half the mothers in the survey and 70% ended up with stitches. Commenting on this, Rosemary Jenkins of the Royal College of Midwives said that it took time for new practices to filter through even though she thought that midwives were aware of recent research on episiotomy. **Elizabeth Key.**



LET THEM EAT CAKE

The Community Health Council News reported that during the sit in at the Bolitho Maternity Hospital in Penzance - local MPs asked in the House how women were supposed to get to the hospital in Truro 40 miles away if the unit is closed.

The hospital car service had been discontinued, there is little or no public transport, and many families are too poor to own a car.

Edwina Currie replied.....
"They can take taxis"

PUBLICATIONS LIST AND ORDER FORM

1. **AIMS Quarterly Journal.** Price £2.00
The AIMS Quarterly Journal spearheads discussion about change and development in the maternity services. It is highly regarded, both by parents — who find it an excellent source of information and support — and by workers in the field — who frequently write to AIMS to say that the Journal is the best source of information of the kind available.

2. **Who's Having Your Baby? – A Health Rights' Handbook for Maternity Care** Nov. 1988. pp126. Price £5.55 inc. p&p
This best selling book has expanded on the original Health Rights' Handbook. It gives information and advice about the choices available in maternity care. A guide on how to go about getting what you want, what your rights are, and it discusses extensively the issues involved in medical research and the use of obstetric technology. A must for any mother who wants to be informed about childbirth.

3. **A Commentary on the Report of the Royal College of Obstetricians and Gynaecologists Working Party on Routine Ultrasound Examinations in Pregnancy.** June 1985. Price £1.00
The RCOG produced a report on the use of ultrasound examinations in pregnancy which appeared to be an exercise in allaying public concern about possible risks of ultrasound use. The AIMS commentary critically examines the report and comments on the statements made.

4. **Drugs in Labour and Birth.** Spring 1987. Price £2.50
A seven page article setting out the facts about drugs used in labour and birth, and their effects on both mother and baby.

5. **Some Readings on the Third Stage of Labour.** January 1986. Price £1.00
A collection of papers which discuss the use of syntometrine for the delivery of the placenta and argue for a natural third stage delivery.

6. **Choosing a Home Birth.** January 1986. Price 50p
A leaflet which advises parents on the pros and cons of home birth and what steps a mother should take should she decide to give birth to her baby at home.

7. **Choosing a Hospital Birth.** January 1986. Price 50p
A leaflet which advises parents on the advantages and risks of hospital birth, what choices there are and what steps should be taken should the mother decide to give birth to her baby in hospital.

8. **Improving the Maternity Services - What Can I Do?** September 1984. Price 15p
A leaflet which gives suggestions to those who are considering pressing for better maternity care provision in their area or nationally.

9. **What is AIMS?** September 1984. FREE
A leaflet which briefly describes the activities of AIMS, the campaigns it has fought and the campaigns it is currently conducting.

10. **Select Book List.** August 1986. FREE
A list of selected books about childbirth issues

21. **AIMS Badge.** 10p each
A 1" metal badge of the AIMS logo.

Occasional Papers

11. **Birth is a Normal Process - A Mothers Perspective.** April 1985. Price 75p
This paper was presented to the World Health Organisation Conference on "Appropriate Technology for Birth" and discusses womens' perceptions of normal childbirth and the way in which technology and centralised hospital birth has perverted this process.

12. **The Role of 'Consumer Advocacy' in Birth Care.** April 1985 75p
This paper was also presented to the WHO Conference on Appropriate Technology for Birth and discusses the role of the consumer organisations, their achievements, failures, and hopes for the future.

13. **Perinatal Services and Prenatal Care - A User Perspective.** Nov. 1984 price 75p
This paper was presented to the WHO conference on Appropriate Technology for Prenatal Care held in Washington in November 1984 and discusses the provision of perinatal services and prenatal care and the work and objectives of the user organisations.

14. **The Pregnant Womans' Need for Information: Medicine Use in Pregnancy and Birth.** October 1984 Price 75p
This paper was presented to the 13th European Symposium on Clinical Pharmacology Evaluation in Drug Control, November 1984 and discusses drug usage in pregnancy and birth and the amount of information and advice given to women.

15. **Childbirth in Hospital: The Choice of the Mother or Right of the Child?** January 1986 Price 75p
This paper was presented to the London Medical Group and examines the risks, to themselves and their babies, taken by those who decide to give birth in hospital.

16. **The Importance of Choice in Childbirth.** November 1985. Price 75p
A discussion of the necessity of maintaing a range of options available to mothers. How parents choice has influenced maternity care.

17. **Pain Relief in Labour - Women's Perspectives.** March 1986. Price 75p
This paper was presented to the Maternity Alliances Conference 'Pain Relief in Labour: The Benefits and Risks' and discusses the way in which hospitalised childbirth practises result in women needing drugs for pain relief.

18. **Survey of Local Maternity Units.** 1985. FREE
A questionnaire which women can send to their local maternity units. It seeks to establish the policies of the local units and obtain hospital's statistical data. An analysis of the responses received by AIMS will be published at the end of the year.

19. **How to Oppose a GP Unit Closure.** Price £2.50
A booklet which provides information and suggestions to help those who are fighting the closure of their local GP units.

20. **AIMS Envelope Labels.** 100 for 50p.
Sticky labels with the AIMS logo, useful for re-using envelopes.

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1. **AIMS Quarterly Journal** @ £2.00 each .... copies £.....
Back issues of the Journal @50p each .... copies £.....
2. **Who's Having Your Baby?** @ £5.55 inc P&P .... copies £.....
3. **RCOG Ultrasound Report** @ £1.00 each .... copies £.....
4. **Drugs in Labour and Birth** @ £2.50 each .... copies £.....
5. **Readings on Third Stage of Labour** @ £1.00 each .... copies £.....
6. **Choosing a Home Birth** @ 50p each .... copies £.....
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14. **The Pregnant Woman's need for Info.** @ 75p each .... copies £.....
15. **Childbirth in Hospital** @ 75p each .... copies £.....
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DIARY

SPECIAL CARE BABY WEEK

May 14th to May 20th 1989

Culminating in a two day CONFERENCE

For details contact:
NIPPERS (National Information for Parents of Prematures: Education, Resources, and Support) c/o Sam Segal Perinatal Unit, St. Mary's Hospital, Praed Street, London W2
Tel: 01 992 9310

WORKSHOP ON DRUGS IN PREGNANCY AND CHILDBIRTH

With Judith Priest

SAT. 17th June 1989
11.00am - 4.30pm
at
The Manor
Standlake
Witney, Oxon
Tel. 086 731 266

Make booking by tel. or in writing before Wed. 7th June Cost: £14 (contributions for a buffet lunch)

THE ROYAL SOCIETY OF MEDICINE - FORUM ON MATERNITY AND THE NEWBORN

'Prenatal Diagnosis - Where Do We Stop'

The need to consider the costs as well as the benefits to be derived from this ever-increasing activity.

Wed. 7th June 1989: 6.00 pm

Programme information and details of membership of the Forum are available upon request from:
Barbara Komoniewska BA,
1 Wimpole Street
London W1M 8AF

INTERNATIONAL DAY OF ACTION FOR WOMEN'S HEALTH

28th May 1989

THE MATERNITY ALLIANCE CONFERENCES

"The Cost of Living: Eating for Pregnancy and After"

Two conferences designed to raise professional and public interest in the problems of achieving a healthy diet in pregnancy and early parenthood for women on low incomes and to devise strategies for health education and further action.

9th May 1989 - London
13th June - Newcastle

Tickets £25 - £30
Information & booking form:
Chris Smith
The Maternity Alliance
15 Britannia Street
London WC1X 9JP.
Tel: 01 837 1265

"WHAT WILL BIRTH BE LIKE TOMMOROW?"

In homage of Fernand Lamaze
A conference organised by Les Rencontres de Paris to bring together all the people involved in birth.

6th, 7th, & 8th May 1989 at the Parc Floral de Paris, Bois de Vincennes, PARIS

For further information:
Le Secretariat
9, Rue des Bluets
75011, Paris.
Tel: (1) 43.55.44.09

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If a new member, how did you hear about AIMS?

.....

If you would like to help AIMS but feel you cannot afford the membership fee, please send what you can. We do not want to debar anyone from membership on account of low income; above all we value your involvement and support. Thank you.