Obstetrics after the white paper

Geoffrey Chamberlain

Working for Patients[1] and the discussion papers offer such an insubstantial framework for change that it is likely that managers will write their own scenarios for local services—risking a return to the patchy local variation in medical services that existed before 1948 and was corrected by the National Health Service. Money looms so large in the white paper that its aim seems better economics rather than better health care; this could tempt the less scrupulous managers to put on one side parts of the service in favour of those aspects that might have a better financial return. The practice of obstetrics is at risk from both these trends.

Obstetrics is hardly mentioned in the white paper or the discussion papers. Perhaps obstetrics will be considered as a core subject under the acute services provided in every health district and therefore not for negotiation. Most large obstetric units are in the hospitals that might consider becoming self governing; up to now they have struck a fine balance between looking after residents in their own health districts and caring for the tertiary referrals from outside the funding health district. This balance would inevitably be upset if the values of the market place became dominant. The white paper threatens the delivery of obstetric care in several ways. I foresee problems for mothers and their babies, for contraceptive services, and for teaching and training.

Antenatal care

Antenatal care requires that many healthy women are screened to pick up the few with problems. As such it may hold little attraction for managers looking for quick financial returns. Community midwives and general practitioners currently provide most low risk antenatal care, readily referring women to hospital when problems are found. Will this system stand the double pressure of general practitioners holding on to cases because of budget commitments and managers resisting taking women who might be outside their planned budgets?

Delivering care

When it comes to intrapartum care in the United Kingdom a recent survey showed that 67% of deliveries took place in hospitals performing more than 2000 births a year, 28% in units delivering between 501 and 2000 a year, and only 5% in sites delivering less than 500 a year.[2] But the numbers of units in these groups was respectively 125, 149, and 217. Under the white paper's proposals the small units undoubtedly will go to the wall, even more rapidly than they are doing at present. Units with 501 to 2000 deliveries a year are also at risk, many of them scattered in the smaller towns around the country. Closure will have grave implications in the movement of women in early labour and will need careful reconsideration of the old flying squads which drew doctors out of the larger hospitals, leaving the women at most need cared for less well. If obstetrics is taken as a core subject then a balance will be struck between the number of deliveries performed among the smaller local hospitals and those that pass to the larger units as tertiary referrals either late in the antenatal period or in labour itself.

The capacity of an obstetric unit is ultimately determined by how many deliveries a hospital can cope with, and levels of staffing are obviously crucial. Hospital managers need reminding that average loads are poor guides to need: they should plan for maximum load if staff shortages are not to occur at certain times, thereby endangering mothers' and babies' lives. Variable load has always been a problem in acute midwifery and, when budget constraints bite, financially minded managers may be tempted to restrict expensive staff in the name of rationalisation.

. . . I foresee problems for mothers and their babies, for contraceptive services, and for teaching and training.

Postpartum care

Postnatal care has shifted towards earlier discharge from hospital and more participation from general practitioners and community midwives. Care must be taken that finances do not dictate how long women stay in hospital after delivery. If a further shift leads to even earlier discharge then the community services will need increasingly to give proper obstetric care to women.

Before discharge a few babies will need neonatal intensive care, a service poorly provided for in this country.[3] It is most unlikely that such a service could ever be made cost effective and the already inadequate services provided in many regions might be under threat if hospitals tried to alter them for financial reasons. Two possibilities exist. Some district managers may see neonatal intensive care as a source of income. They may reopen some neonatal facilities in inappropriately small hospitals, leading to understaffing by neonatal nurses and doctors who would not get much experience. Alternatively, district health authorities may try to opt out of providing neonatal intensive care, transferring babies that need it to a central regional unit, which would be swamped.

Contraceptive services

Contraceptive services will also be affected. While many family practices give a good service in some cases this does not exist or is limited mostly to the prescription of oral contraceptives. Some women may not wish to see their general practitioner. Family planning clinics, about which many planners seem hardly to have heard, look after many of the young, the poor, and the unemployed. Since contraception became a free service those who work in family planning clinics have seen many more from these groups needing help. Whether this will continue under the keen searchlight of financial limits is doubtful. Clinics also provide a referral point for difficult cases of contraception; to

Department of Obstetrics and Gynaecology, St George's Hospital Medical School, London SW17 0RE
Geoffrey Chamberlain, FRCOG,
professor and chairman

Br Med J 1989;298:1702-3

be available, they need to see a reasonable number of women for the training of family planning practitioners.

Teaching and training

Student teaching depends on a mix of straightforward and complex obstetric problems being available to undergraduates. This balance may be disturbed if large teaching hospitals become self governing. Postgraduate training of doctors in obstetrics will continue to be regulated by the Royal College of Obstetricians and Gynaecologists, although conflicts may arise between self governing hospitals and the college over appropriate staffing levels and the number of patients available for teaching purposes.

. . . district health authorities may try to opt out of providing neonatal intensive care.

A shift in the balance of obstetrics between hospitals and family doctors may happen. Fewer potential general practitioners will want to do senior house officer posts and take the DRCOG. Units will have to depend on career minded junior doctors. With the uncertainties about a future in obstetrics in mind, this may mean a limit in the non-teaching hospitals of the number of pairs of hands actually doing the labour ward work.[4]

Audit

Medical audit is the only feature of the white paper about which there is general agreement. With the Confidential Enquiry on Maternal Mortality and the collection of regional data on perinatal deaths obstetrics has probably been auditing its performance longer than most medical specialties. Obstetricians have therefore learnt to appreciate the limitations of using easily collected indicators of health outcome to evaluate medical performance. For example, while perinatal and neonatal mortality rates may be useful at a national or even regional level, the numbers in a district will be a poor guide to services. In countries like the United Kingdom the effect of socioeconomic factors on variations in perinatal mortality is far greater than that of medical facilities. Unless managers are careful they may mistake the socioeconomic constitution of their population for a meaningful measure of doctors' performance.

Conclusions

The presentation of the white paper has antagonised the medical and nursing professions. The lack of consultation and the abrupt handling of criticisms by ministers have led to a head on confrontation that will be hard to disentangle. Yet there may be ideas for obstetrics in *Working for Patients* which both sides should discuss and devise timetables for planned changes. As it stands, little time has been allowed for the professions to comment. The Department of Health has set up pilot studies, but the minister did not wait for the results of these; like an unsupervised research worker, he is rushing on to perform more experiments without analysing the results of the ones that he has done. Those who are wise in health economics would advise that similar experiments have already been done and have been shown to have failed in the United States.[5]

Despite advice like this the government still rushes down hill. At the moment the time scale for implementing the new health service seems to relate to the next general election. If politicians could put election campaigning to one side and allow a proper decade of planning, experimentation, and implementation a much improved new health service might exist by the year 2000.

1 Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients.* London: HMSO, 1989. (Cmnd 555.)
2 Chamberlain GVP, Gunn P. *Birthplace.* Chichester: John Wiley, 1987.
3 Royal College of Physicians. *Medical care of the newborn in England and Wales.* London: Royal College of Physicians, 1988.
4 Chamberlain G, Drife J. Achieving an inbalance in obstetrics. [Editorial]. *Contemporary Reviews in Obstetrics and Gynaecology* 1989;1:103-4.
5 Black D. A Black look at a white paper. *J R Coll Physicians Lond* 1989;23:66-7.

MATERIA PARAMEDICA

Leeches for leeches: hirudines for medicos

Well, blow me down! So leeches are back, and are doing a good job relieving venous congestion in plastic and reconstructive microsurgery. They are even bred for the purpose. It must surely be at least three quarters of a century since leeches were in common use. It was believed that they decongested underlying viscera and were an alternative to cupping and the spring loaded scarificator. I may have been the last physician in this country to use leeches at the tail end of that era. That was in 1940, when the practice was virtually obsolete. But the story begins six years previously.

In 1934, a boy of 10 years of age was admitted to Westminster Hospital under the care of Dr Hildred Carlill with acute rheumatic pericarditis. Carlill was a man with a sharp, dominating personality, but with some endearing minor eccentricities. The boy was acutely ill with a fever maintained at around 104°F (40°C). As there was no improvement during the first week, Carlill ordered the application of two leeches to the skin over the boy's sternum. Even in those days it was thought to be a quaintly archaic form of treatment and without any scientific basis. The following day the boy's temperature fell to normal, and he made an uninterrupted recovery.

In 1940 I was on the staff of Archway Hospital, which was then the district hospital for the borough of Holborn and administered by the London County Council; now it is a wing of the Whittington Hospital. I often lingered in the "dispensary" to chat with the amiable Scottish pharmacist. Among items under his care were a Latin grammar (we still prescribed in Latin then) and a glass jar containing water, at the bottom of which lay several immobile leeches. I have no idea what if anything they fed on, and they seemed to be in a state of permanent hibernation. Certainly they were underemployed. One day a boy was admitted under my care with acute rheumatic pericarditis. There was much acute rheumatism around in those days. He ran a high fever for several days despite salicylates. On his treatment sheet I wrote the words, "Hirudines, duo." Ideally, I thought, this should have been written with a quill pen. Two leeches were applied to the skin over the boy's sternum. They were encouraged to bite by smearing on a little sugar water. In my mind's eye I can still see the boy crying, but whether from pain or fear I know not. Leeches change shape and look ugly when they are sucking. Well, you can guess the outcome. The temperature fell to normal the next day, and the boy made an uninterrupted recovery.

Coincidence? Your guess is as good as mine. But, just a minute. Perhaps leeches are waiting to tell us something about treatment that we don't know.—BERNARD J FREEDMAN