dear Noel Coward. Then I played in *Macbeth*. I was the apparition and Duncan's child. I had, of course, to be killed, and it was funny when as the apparition wearing a silken veil, and with my throat gashed, the veil caught fire at the cauldron and had to be quenched by the witches. Ha, Ha! Those were the times."

I declined a cigarette, pointing out with some regret that I had given them up. "Yes, you lose something, and I suppose you gain something. Smoking is a peculiar habit. It is not really a pleasure other than in a negative sense. Colette, that superb creature, put it so well; she said, smoking really minimises discomfort—if you are bored and smoke, you become a little less bored; if you are nervous and tense, you become a little less nervous and tense; if you are in pain, your pain is lessened. Don't you think that is the essence of smoking?"

He went on to discuss Colette. "Oh, how I would love to have

met her. I adored her. She was, of course, old when she died—in her 80s, I think. The world waited for Jean Cocteau, her great friend, to speak and satisfy its morbid curiosity about Colette. But, he was so shaken, so upset, and so honourable—he was, as you know, queer, and she, the darling, was everything—that all he could say was: 'We loved as brother and sister, as man and woman, she was my dearest friend.' Don't you think that is beautiful, truly beautiful?"

A little later we reached Le Havre, and I waved goodbye to Micheál and his travelling companions as they set off on their Continental Odyssey. I went on to Paris, haunted by a memory, his words ringing in my mind. No wonder he was so fascinated by Wilde—they were so alike in many ways. Unique artists with a common background—Dublin. May they enjoy pleasant converse in the Elysian fields.

Medical Controversies

Expectations of a pregnant woman in relation to her treatment

British Medical Journal, 1978, 2, 188-191

What are the reasonable expectations of a pregnant woman in relation to her treatment? A group set up by the National Childbirth Trust has prepared a list of ten items, set out below, which were discussed recently by Lady Micklethwait, president of the NCT, Professor Richard Beard, professor of obstetrics and gynaecology at St Mary's Hospital, London, Miss Kathleen Shaw, divisional nursing officer, the West Middlesex Hospital, and Dr Tony Smith, deputy editor of the *British Medical Journal*.

(1) She would at all times receive factual information about her medical state and that of her baby. She would also be told about the care they would receive in pregnancy, labour, and the postnatal period.

(2) It would be assumed that she would go into labour normally unless it was considered to be unsafe for her baby or her. The problem would be discussed with her before a decision was made to induce labour.

(3) She would proceed normally in labour without intervention unless there were indications that this might be unsafe for her or her baby.

(4) She would have the various available methods of pain relief explained to her before labour and would be allowed to

decide which she wanted and when it would be given—she would not be put under pressure to accept it.

(5) If it was considered necessary to induce or speed up labour for reasons of safety, the matter would be discussed with her before the decision was taken.

(6) She would, if she wished, have her husband or another person of her choice with her throughout labour.

(7) She would like, if it were possible, to have someone around during her labour who had given her some antenatal care.

(8) When her baby is born, she would hold him as soon as possible, and spend some time with him and feed him if she wished to, unless either of them required urgent attention.

(9) Throughout her stay in hospital she would not be separated from her baby unless she wished or it was considered essential. She would be allowed to feed him at any time.

(10) Professional advice and support would be readily available to her for as long as she needs it when she returns home.

Discussion

DR SMITH: Could we start, Lady Micklethwait, by your explaining just how the "expectations" document got to be written at all?

LADY MICKLETHWAIT: At the National Childbirth Trust we were receiving a great many letters from parents asking about their rights in relation to treatment in pregnancy and in labour. For example, women wanted to know if they had a right to have their husbands with them, or a right to have a baby at home, or to refuse an injection of pethidine. Since people use the word "rights" in so many different ways I called together an obstetrician, a lawyer, a sociologist, a biologist, an antenatal teacher—in fact, a whole range of attitudes. Many of the participants were also parents. We met to discuss parents' rights and to look at things like treatment in hospital and the demand for home confinements. Among the things we had in front of us was a letter from one woman (whom I had not met) who said she had tried to work out the main items which she could realistically

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expect the medical profession to promise her. Her list was the basis of the points we drew up at our first meeting. And we then circulated that list for comment, then met again.

DR SMITH: Most people would say it looks a fairly reasonable set of "expectations," but is it going to change attitudes? Is not this sort of thing already done by a good obstetrician? Throughout, the list of "expectations" suggests that with adequate explanation by the obstetrician or the midwife there would be no disagreement between the patient and the professional as to what should be done. I think that begs the question. It might very well be that an obstetrician who believes in induction at term will come across a patient who has thought about it and who doesn't like the idea. Who is going to make the choice?

"No one is expert any more in obstetric emergencies in the home"—Miss Kathleen Shaw.

PROFESSOR BEARD: From the start I think it is important to define the objectives of the patient and her obstetrician. Most women are reasonable people who recognise the advantages of having a good relationship with their doctor. Even so, they have come to expect pregnancy to be safe and wish to have some say in what for them is one of the most important events they will ever experience. The obstetrician sees himself as the guardian of the welfare of the mother and her baby. A conflict of objectives may arise if either the mother makes unreasonable demands that are liable to endanger her or her baby, or alternatively if the obstetrician fails to convey to his patient why he is taking a particular course of action, or adopts an obviously unreasonable attitude.

The list of "expectations" represents an attempt to find a formula that patients, midwives, and obstetricians can use as general guidelines in their relationships with each other. We hope that general acceptance may help to overcome some of the "confrontations" you refer to. Certainly there is a need to get away from the relatively fixed attitudes that have been taken up in recent years between pressure groups and the profession.

MISS SHAW: Sometimes patients feel that they've been pressurised by their obstetrician. A woman may start off with the idea that she does not want an epidural analgesic, while the obstetrician believes it would be right for her. The patient eventually finds herself accepting it and then in retrospect she says that she did not really want it and that the obstetrician had persuaded her against her wishes.

Home confinement

DR SMITH: And there must surely be a few occasions where there is this sort of conflict. If you have a woman with a bad obstetric history who nevertheless says "I want my baby at home and I'm not going into hospital," it is going to be very difficult. . . .

PROFESSOR BEARD: I agree. Conflict must occur sometimes but on those occasions one has to say that there is a limit to the ability of an organisation like the NHS to provide a safe service. There is a point where a mother has to accept responsibility for the welfare of herself and her baby if she refuses medical advice.

MISS SHAW: One of the problems that community midwives see at the moment is that midwives are now geared towards caring for all patients in hospital. Occasionally a woman is adamant that she will have her baby at home despite all the advice she has been given; she may be quite unsuitable for home confinement—and, as midwives, we then feel that we are left unsupported because no one is expert any more in obstetric emergencies in the home.

PROFESSOR BEARD: You are quite right: there is always a point when a service is so little used that those who work in it do not get sufficient experience.

DR SMITH: Options are going to change as practice changes: perhaps in another ten or twenty years very few people will be equipped to do a breech delivery because breeches are delivered by caesarean section. And so what happens then to the woman who says "I don't want a caesarean section. People have had breech births since time immemorial, so why can't you provide this service?"

MISS SHAW: What happens now is that the patient stays at home until she is almost in the second stage of labour and desperate, then we get a 'phone call and somebody has to go to her house to try to deliver a breech presentation in the worst possible circumstances.

Rigid attitudes

PROFESSOR BEARD: I think the demand for home confinement is much smaller than it is sometimes made out to be. Probably many women would like to have their baby at home if their doctor thought it was safe, but since this is not so they are quite prepared to come into hospital. It is rare that the problem you describe develops if the patient has met with a generally sympathetic attitude when she first attends her local hospital.

LADY MICKLETHWAIT: I agree. I've had letters from couples who have said if only "they" hadn't all ganged up on us and said no and made my wife cry every time she went to the antenatal clinic. If only they had said "well, perhaps, let's discuss it," things would have been different. And I'm interested to hear you say that it's the unsuitable patient who demands a home confinement. The ones I hear about particularly are women who would certainly be in a low risk category and who opt for a home confinement because they want to avoid intervention of many kinds.

DR SMITH: A wish to avoid interventionist hospital obstetrics must be a bad reason for wanting a home confinement.

PROFESSOR BEARD: I am not too sure about that—I think most of the "confrontations" between the public and profession have developed because we have failed to recognise the sense of achievement women feel if they are able to deliver their baby unaided. Extremist attitudes have developed out of misunderstandings between obstetricians and patients, and often quite trifling misunderstandings that could be overcome by a change in philosophy. If obstetricians no longer take the paternalistic view, if they accept that their patients are intelligent people who like to take some personal responsibility, and allow them to take personal decisions by giving them as much knowledge as possible, then misunderstandings are unlikely to develop. Clearly, when there is a complicated clinical problem the decision must be handed over to the obstetrician, but the options can surely be

"It would be unrealistic to expect obstetricians to give up practices that have contributed to making pregnancy safer simply to satisfy some of the emotional needs of their patients"—Professor Richard Beard.

left open for the patient for routine procedures such as administering an enema or shaving the pubic hair?

MISS SHAW: Certainly. We try to think nowadays in terms of the patient making some contribution in her own treatment: it is right that she should have a degree of choice. How much choice she should have is less clear.

DR SMITH: Whenever there is room for compromise, it is more reasonable that the patient should be at least one of the voices heard in deciding what that compromise is going to be. Presumably, that should provide no difficulty, so long as there is time for these discussions to take place.

MISS SHAW: Problems may arise in the delivery suite when decisions must be made quickly.

DR SMITH: For example, should the cord prolapse that is not the moment to start discussing with the mother what the implications are and what needs to be done about it.

LADY MICKLETHWAIT: Surely that is an example of something that should be part of antenatal preparation—every mother should understand about emergency events and there should be opportunities for discussion during pregnancy.

PROFESSOR BEARD: Antenatal preparation is certainly the most important component of any obstetric service that tries to implement the "expectations."

Continuity of care

DR SMITH: One of the listed "expectations" that may prove difficult in practice is continuity of care.

PROFESSOR BEARD: Yes, there is an almost insuperable administrative problem in ensuring that the same doctor and

"Women . . . opt for home confinement because they want to avoid intervention"—Lady Micklethwait.

nurse who is seeing the patient in the antenatal period is available when she comes in in labour. It would be much more realistic to try to provide continuity of care in pregnancy and then again in labour. Duty rotas and job descriptions make it impossible to bridge the gap between pregnancy and labour.

LADY MICKLETHWAIT: Item 7 on the list says that if possible she would like to have someone around during her labour who'd given her some antenatal care. I think there is a big misunderstanding here which affects doctors more than anyone else. I was talking to a large meeting of women today and they said it wasn't the doctor that they meant: what they wanted was a midwife whom they had seen in the antenatal clinic—or possibly a pupil.

MISS SHAW: In my unit 12% of patients are delivered by community midwives—and those most certainly have had continuity of care. It is only a few patients, and is achieved only because we have moved heaven and earth to maintain their skills by encouraging the community midwives within the hospital. For the rest of the patients, it is almost impossible to ensure that the patient has a midwife who has seen them antenatally: staff working in the antenatal clinic tend to be part-time (in the day) and it's almost impossible to interchange staff.

PROFESSOR BEARD: The fact that women who have had a baby see the need for continuity of care as important may well be the product of a feeling of loneliness when they come into hospital. Often they feel a hostile atmosphere. One way of improving this is to create a sympathetic atmosphere by ensuring that every woman is welcomed as she comes into the labour ward—something that is often overlooked when the unit is busy or short-staffed.

MISS SHAW: We believe that it helps a great deal if the person who admits the patient cares for her then for at least six hours. We have comfortable chairs in the delivery room and the staff sit down and talk with the husband and the patient while they wait. They quickly get to know each other—so that there is a friendly homely atmosphere.

DR SMITH: Is it indeed possible to provide an individual midwife or nurse for each patient who will stay with her throughout the whole of her labour?

PROFESSOR BEARD: I have no doubt that this is what we should aim at.

MISS SHAW: My community midwives don't go off duty until they have completed the care of that patient, unless they themselves elect to do so. There is certainly no hard and fast ruling about their hours. Very often the hospital staff will stay on too.

PROFESSOR BEARD: While such an approach is ideal, it is difficult to achieve it as part of a routine service. However, I

absolutely agree with the spirit of the sentiment. There is no time in the whole of pregnancy when a woman is in such need of reassurance and support from those who are looking after her than during her labour.

Poor communication

DR SMITH: How much do staff shortages account for the dissatisfaction felt by some women? Is the explanation that people are harassed and short of time?

PROFESSOR BEARD: Undoubtedly, staff shortages do contribute to a feeling of tension in clinics and on the wards. Recently, with the financial cuts in the NHS, we have seen a deterioration in the relationships between staff and patients, simply because there is no time to sit and talk to the patient. This is particularly disruptive on the postnatal wards, where women need plenty of advice and support at a time when they are emotionally more labile than usual. I would like to take this opportunity of reiterating what I have said, that any reduction in the financing of the maternity services for economic reasons is short-sighted and certain to lead to a deterioration in the quality of care. The "expectations" we are talking about cannot be realised without a generous provision of staff.

LADY MICKLETHWAIT: From the patient's point of view it sometimes looks as if the greatest anxiety of midwives is in coping with the machines in the delivery room rather than spending time with the patient.

PROFESSOR BEARD: Certainly instruments can give rise to anxiety, which may distract the attention of the midwife from the patients. However, it is also true that instruments can reduce the work load thereby giving staff more time to talk to the patients. Conversely, a major problem is that many midwives are not being adequately trained in modern methods of management of labour. We are, at the moment, in a transitional period when modern monitoring techniques are coming to be accepted as an established part of clinical practice and therefore of the training of midwives.

Husbands in the delivery room

DR SMITH: One item that struck me as possibly slightly provocative was number 6, that the husband should always have the right to be present in the delivery room. There are some difficult and aggressive men.

MISS SHAW: It's better to have them in the delivery room where they can see what is happening. Once there, their apprehension is reduced because they can see that we are not doing anything terrible to their wives. They only become really aggressive if they are excluded.

PROFESSOR BEARD: I think that's right, but I can see a danger if it became an absolute right: you could imagine an acute emergency, when only those looking after the patient should be in the room, yet the husband or boyfriend says "I'm staying."

LADY MICKLETHWAIT: That is why we should not call the list of "expectations" a charter. We might qualify this—I was going to say a "right" if that is what it is—this right for a woman to have her husband or another person with her, by saying that that person should have had some sort of preparation for the experience.

MISS SHAW: Years ago we asked that the husband who wanted to be present should come to parentcraft classes. Then we didn't encourage anyone else to come in, thinking that the patient's mother might well become far too emotionally involved. In recent years we've been happy to see husbands, mothers, or boyfriends present.

PROFESSOR BEARD: I think the principle should be that it's the person that the woman wants to have with her that is important, not necessarily who he or she is.

LADY MICKLETHWAIT: The purpose of having this other person there is to support the woman—that's the real aim.

DR SMITH: To some extent it's true to say that a husband or a father may want to be there because he feels that the baby is his too. It may be that his relationship with his wife is such that she doesn't want him, as she would put it, fussing around talking to her.

MISS SHAW: But if she doesn't want him she wants a midwife, she wants somebody talking to her and guiding her.

PROFESSOR BEARD: This does bring out the question of the role of the midwife or doctor. He or she may be criticised for the tendency to adopt a possessive attitude to the patient. That is not to say that there is no place for emotional support for the patient from her attendants—it is simply that I believe the most natural relationship of the patient with her husband, which may be almost suppressed in hospital surrounds, needs to be encouraged. At no time should the attendant, whether midwife or doctor, intrude on the relationship between the patient and her husband.

Paternalism

DR SMITH: Are there any occasions, Professor Beard, when you feel that it was right to take the paternalistic view?

PROFESSOR BEARD: Perhaps paternalism is not the right word. Certainly there are often occasions when professional advice is needed. The force with which it is given and by whom depend on the assessment of the patient. As in all things in life, some people are better at it than others.

MISS SHAW: There is nothing very much that one could think of that should be concealed from the patient. Indeed, we have some of our patients carrying their own notes (because we have decentralised antenatal clinics) and we talked this through at length before starting it. We came to the conclusion that really the only thing that we might write in the notes that could cause patients concern would be when we were doubtful or fearful that there was a fetal abnormality.

PROFESSOR BEARD: In Sweden for some years the law has been that patients have access to their notes—and in consequence doctors just don't write anything on the notes, so that communication between doctors is absolutely nil. For example, if the obstetrician suspects the baby's growth is retarded, it is not in the best interests of most women to know what is in his mind until the matter is settled, or at least explained in detail to her. But it is essential that doctors should be able to communicate freely with each other without the worry that their patients might misinterpret their thoughts.

LADY MICKLETHWAIT: When the list of "expectations" first appeared in the journal *Midwife, Health Visitor, and Community Nurse* a comment was made that the proposals were concerned with communication and tender loving care. I think they are about something more than that—about whether we think there

is an actual advantage to the mother and her baby in labour starting spontaneously if she is prepared to wait for it to do so if she is late, and whether there is an advantage in labour which proceeds without augmentation.

DR SMITH: We could turn the concept round the other way: if such "expectations" came into operation some obstetricians might very well believe that women were exercising their choice to have their labour conducted in a way that perhaps marginally increased some of the risks to the fetus. So long as that is an informed decision on their part, it is a reasonable decision for a woman to take. If she says "no, I'm going to hang on and wait for baby to start spontaneously," then all the obstetrician can do is to say "at this stage you should know that it is against my advice but it is up to you."

PROFESSOR BEARD: I have to agree with you, but the list of "expectations" is certain to affront people who really believe that the obstetrician should be left to do his job to the best of his ability, unimpeded by having to explain everything to his patient. Some see it as a matter of trust that is an essential component to the doctor-patient relationship. I believe that if women have a better relationship with their obstetricians then a more useful discussion will develop, which will improve obstetric practice.

MISS SHAW: If there isn't any real rapport between the consultant and the patient which is built on trust then the patient won't be able to say "I know about inductions and I don't want one." Also if she sees a different person every time—which is one of the criticisms of antenatal care in many hospitals—or if she feels that she doesn't know anyone she's not going to voice her opinion at all.

PROFESSOR BEARD: All of us in the profession are unhappy about the misunderstandings which have developed in recent years. I do not believe that they are serious, but they do need to be aired by discussion. I hope that our list of "expectations" will go some way towards creating a rapprochement that will lead to a better understanding between our patients and us. These misunderstandings are the product of women becoming more questioning about all aspects of their life and in particular about a function that is as exclusive to them as women as reproduction. Equally, obstetricians in Britain are proud of their achievements in making pregnancy so much safer for both mother and baby. It would be unrealistic to expect them to give up practices that have contributed to this achievement to satisfy the emotional needs of their patients.

What is required is a balance between practice done in the interests of the safety of mother and baby, and what is reasonable to allow to ensure that pregnancy is a good experience for the mother. Our list of "expectations" is certain to be considered too extreme by many in the profession, and not to go far enough by some women. What we hope is that they will create a basis for creative discussion on a subject which has, so far, been remarkable for its lack of benefit to pregnant women.

may show evidence of infection more easily than healthy people with a normal defence mechanism. Koivisto and Felig² have recently shown that in diabetics the usual routine preinjection swabbing of the skin with 70% isopropyl alcohol for 5 s removed 80-90% of the surface skin bacteria. Omitting this ritual procedure before subcutaneous insulin injection did not result in clinically demonstrable infection. Their patients' skin was apparently socially clean. The authors concluded that "routine skin preparation with alcohol before insulin injection may not be necessary to prevent infection at the injection site." Many diabetics appear to inject insulin into their socially clean skin without any special swabbing. Nevertheless, it seems advisable, not only for medicolegal reasons, for any doctor or nurse to "swab" skin before inserting any injecting or "sampling" needle. They are more likely to be asymptomatic carriers of potentially pathogenic organisms, and they work in an environment more likely to harbour such bacteria than the average diabetic patient.

¹ Elek, S D, *Annals of the New York Academy of Science*, 1956, **65**, 85.

² Koivisto, V A, and Felig, Ph, *Lancet*, 1978, **1**, 1072.

Is sterilisation of the skin before an injection outmoded?

Unfortunately, skin cannot be "sterilised," even preoperatively, because the often deeply recessed skin appendages, such as sweat ducts, are not reached by clinically effective and non-tissue-damaging bactericidal chemicals. These deeply sited micro-organisms, however, can be considered as clinically harmless, "resident" flora as opposed to the potentially pathogenic transient surface bacteria such as *Staphylococcus aureus* or pyogenic streptococci. When the skin is prepared for surgery the possibility that the surgeon's knife will introduce large numbers of micro-organisms through a long incision warrants entirely different cleansing procedures than are even theoretically required for the minute skin puncture of an intravenous or intra-arterial injection.

Elek¹ has shown that a minimum dose of 7.5×10^4 of *Staph aureus* bacteria was required to induce pus formation after intradermal injection, and 10^5 of the same organism injected subcutaneously did not cause pus formation in healthy volunteers. Diabetics, however,