gram would lead to smaller myocardial infarcts in 476 patients (without cerebral haemorrhage) for every one patient with cerebral haemorrhage without myocardial infarction; thrombolysis would be life saving in 19 of these cases. These benefit:risk ratios are even more favourable with thrombolysis before admission to hospital.

Two trade offs have to be considered to maximise benefit from thrombolytic treatment: the sensitivity versus the specificity of whatever methods are used for predicting myocardial infarction, and the increasing accuracy of the diagnosis with the time from the onset of symptoms versus the waning efficacy of thrombolysis. The problem is to find the optimal balance between causing disability or death by giving thrombolytic treatment to those without myocardial infarction and causing disability or death by withholding the treatment from those with myocardial infarction. We suggest that use of ST elevation as a precondition for giving thrombolytic treatment errs in the latter direction.

JOHN RAWLES

Medicines Assessment Research Unit,
University of Aberdeen,
Medical School,
Aberdeen AB9 2ZD

JACQUELINE ADAMS
ROGER TRENT

Cardiac Department,
Aberdeen Royal Infirmary,
Aberdeen AB9 2ZB

1 ISIS-2 (Second International Study of Infarct Survival) Collaborative Group. Randomised trial of intravenous streptokinase, oral aspirin, both or neither among 17 187 cases of suspected acute myocardial infarction: ISIS-2. *Lancet* 1988;ii:349-60.
2 Rawles JM. Risk benefit analysis of thrombolytic therapy for acute myocardial infarction: a perspective. *Coronary Artery Disease* 1992;3:1153-61.

Changing childbirth

Report is wrong to dismiss poverty

EDITOR,—Having just read the report of the Expert Maternity Group on changing childbirth,[1,2] I am drawn to point 2 in its introduction: "The Group recognised that because of its remit, it would be unable to address issues such as nutrition and socioeconomic factors which can influence the outcome of pregnancy and childbirth."[1] Where, then, will be the discussion of choice for mothers who live in deprived areas who cannot buy decent food for themselves (and their fetuses) and live in unfit housing?

In the north, and indeed nationally, indices of deprivation are closely correlated with low birth weight,[3] as with other health indices such as premature death and permanent sickness. It is disturbing that a report that purports to speak for the needs and wishes of all women is unable to address the issues of most importance to those women with least voice of their own. Laudable in itself, the report is focused so narrowly on middle class attitudes and achievable targets that it fails those in most need.

It is time to bite the bullet, accept the evidence,[4,5] and address socioeconomic deprivation as probably both the main determinant of health and the main restriction on choice for much of the population, including many mothers.

P A CRESSWELL

Newcastle upon Tyne NE2 2ES

1 Expert Maternity Group. *Changing childbirth: the report of the expert maternity group.* London: HMSO, 1993. (Cumberlege report.)
2 Lilford R. Midwives to manage uncomplicated childbirth. *BMJ* 1993;307:339-40. (7 August.)
3 Townsend P, Phillimore P, Beattie A. *Health and deprivation: inequality and the north.* London: Routledge, 1988.
4 Department of Health and Social Security. *Inequalities in health: report of a research working group.* London: DHSS, 1980. (Black report.)
5 Smith GD, Bartley M, Blane D. The Black report on socioeconomic inequalities in health 10 years on. *BMJ* 1990;301:373-7.

Antenatal care must be shared

EDITOR,—Richard Lilford seems to support proposals that midwives alone should manage uncomplicated childbirths.[1] As a general practitioner with 23 years' experience I view these proposals with considerable concern. There is an implication within the report that midwives should not only manage uncomplicated childbirths but all the antenatal care as well. In the near future general practitioners might hardly be involved in antenatal care at all.

It is over 20 years since I last did a forceps delivery and I would not even contemplate trying any intervention in childbirth now. However, our practice does a great deal of antenatal work. This gives great satisfaction to the doctors concerned, and I think that by and large the patients are satisfied with the service we provide. Many medical and surgical problems complicate a pregnancy. Extreme care has to be taken in prescribing any drugs to a pregnant woman. I am not prepared to be presented with a patient about 35 weeks' pregnant who has developed various complications whom I have never seen before in the pregnancy. Many of these problems and associated prescribing are not within the province of the midwives, and I think it is important that the advantages of a team approach are maintained.

Suggestions have also been made to increase the number of home confinements. Again this causes me great concern. I have been involved in the last three home confinements in our practice. The midwives solved potential problems by bringing the entire contents of a delivery suite to the patient's home. This would obviously be impossible if there were any increase in number of home confinements. When there have been a couple of deaths at home or in an ambulance then common sense will prevail. The subsequent million pound medical negligence claim may also for the first time directly involve midwives. Although neonatal mortality figures are perhaps not quite as good as they could be, in a world situation they still compare favourably and are a massive improvement on a few years ago. Let us not deny the enormous achievements and improvements that have been made in maternity services.

I think that improving the working conditions of some of the midwives and junior doctors in the obstetrics services is all that is basically required. At present, doctors and midwives do not have the time to spend with anxious patients or the time to give advice and reassurance. Patients generally are extremely impressed with the services they have received in hospital, and the only complaint that we hear time and time again is that all the staff are far too busy and overworked. Why is it that people in government and positions of responsibility have stopped listening to the professionals who are actually dealing with patients on an everyday basis?

A A STEPHEN

Linden Medical Centre,
Kettering,
Northamptonshire

1 Lilford R. Midwives to manage uncomplicated childbirth. *BMJ* 1993;307:339-40. (7 August.)

Domino schemes preferable to team midwifery

EDITOR,—Richard Lilford[1] critiques the government's recent report *Changing Childbirth*, which makes recommendations for changes to Britain's maternity services.[2] In the attempt to achieve the report's aims the excellent care that many women receive from a combination of a committed midwife and general practitioner obstetrician may be sacrificed. Such women see one midwife and one general practitioner for antenatal and postnatal care and are likely to receive care from one or other when they are in labour.

Such personal midwifery care is threatened by the extension of team midwifery, which to date has failed to provide good continuity of care. The alternative of increasing domino schemes would provide much more continuity for women. These schemes allow a woman to receive her antenatal and postnatal care from her community midwife, who may well deliver her.

Of the 10 specific aims of the report, two merit comment. One aim is that at least 30% of women delivered in a maternity unit should be admitted under the management of a midwife. Because transfer rates may reach 50% this means that over half of all pregnant women would need to be booked for care by a midwife. A more achievable aim might be that 30% should be admitted under the care of a midwife or general practitioner.

Another aim is that at least three quarters of women should know the person who cares for them during their delivery. But in many labours more than one person provides care. Certainly, committed general practitioner obstetricians attend during labour or delivery, or both, in most cases.[3] If the aim was widened so that women should "know one of the people" then it should be achievable.

The report is wrong when it implies that few general practitioners provide intrapartum care: nearly one third still do so.[4] Nearly one in 10 women are originally booked with their general practitioner.[5] To achieve the report's aims, obstetric fees should be paid to only those general practitioners who (*a*) provide intrapartum care, (*b*) have been trained in caring for women with low risk pregnancies, and (*c*) undergo reaccreditation as midwives do every five years. Finally, if general practitioners are asked by a woman for a home delivery they should be able to refer her "directly to a midwife for advice" or to a general practitioner obstetrician.

The report emphasises accessible community based care. To achieve some of its aims, especially those concerned with continuity of care, the participation of skilled committed general practitioners should be encouraged.

LINDSAY F P SMITH

Department of Epidemiology and Public Health Medicine,
University of Bristol,
Bristol BS8 2PR

1 Lilford R. Midwives to manage uncomplicated childbirth. *BMJ* 1993;307:339-40. (7 August.)
2 Expert Maternity Group. *Changing childbirth: the report of the expert maternity group.* London: HMSO, 1993.
3 Bull MJV. General practice obstetrics in Bradford. *BMJ* 1990;300:873-4.
4 General Medical Services Committee. *Report.* London: GMSC, 1992.
5 Smith LFP, Jewell D. Contribution of the general practitioner to hospital intrapartum care in maternity units in England and Wales in 1988. *BMJ* 1991;302:13-6.

Drug treatment during Ramadan

Don't be complacent about diabetes

EDITOR,—J Belkhadir and colleagues examined the frequency of hypoglycaemia in Muslims with non-insulin dependent diabetes in Morocco who were treated with glibenclamide and concluded that it was not aggravated by fasting during Ramadan.[1] Their study, however, contains several methodological deficiencies.

Retrospective assessment of the frequency of hypoglycaemia is unreliable.[2] Retrospective estimates of the frequency of mild hypoglycaemia are inaccurate, and a pronounced discrepancy has been observed between biochemical hypoglycaemia and symptomatic episodes.[3]

Belkhadir and colleagues' patients were asked to rate (also retrospectively) their symptomatic episodes of hypoglycaemia on a six point scale, but it is not clear how this scoring system was used to

BMJ: first published as 10.1136/bmj.307.6907.800-b on 25 September 1993. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.