Reducing perinatal mortality

The dissolution of Parliament has brought a halt to the inquiry into means of reducing perinatal and neonatal mortality that was being conducted by the Social Services Subcommittee of the Expenditure Committee of the House of Commons under the chairmanship of Mrs Renee Short. The committee’s work was timely, since the last 12 months has seen a surge of interest in the care of the fetus and newborn babies, with the publication last year of recommendations for the improvement of infant care by a joint committee from the British Paediatric Association and the Royal College of Obstetricians and Gynaecologists.

Among other factors that stimulated public disquiet was the publicity given in Britain to the greatly improved perinatal mortality figures in France for 1976, and the analysis by the Wynn2 of the details of the 1971 sixth plan of the French Government solely devoted to improving obstetric and neonatal care. Shortly afterwards the Spastics Society ran a national press campaign which drew attention to the wide disparity in perinatal mortality rates in different parts of Britain.

Against that background of public and medical concern, the evidence given to the Expenditure Committee has shown that many of the professional groups responsible for the care of newborn infants believe that more could be done to improve standards. In most parts of the country there is a serious shortage of paediatricians trained in specialised neonatal care.1 Nevertheless, as regional perinatal centres are developed many of these deficiencies will be overcome. In the short term, these centres should solve the acute problem of where to place a sick baby, while in the longer term their facilities for training neonatologists will ensure that gradually more paediatricians become neonatologists, and the district general hospital can provide care for the needs of all but the very sick babies.

Several difficult questions still have to be resolved, including the level of medical staffing required, the effect on the career structure of paediatricians, and the training and recruitment of nurses to a particularly demanding type of acute medicine. And who is to pay for such an expansion? Hard-pressed regions with many other demands on their limited resources are not going to find it easy, and a contribution from central funds may be required. One welcome sign was a recent statement by Mr David Ennals that the Government is to give an extra £10 million next year to improve perinatal care.

Neonatal care is an acute accident service that should be required progressively less as obstetric care improves. In a recent article “Why Blame the Obstetrician?” Illingworth2 argued that many of the cases of perinatal death now regarded as preventable are unavoidable because their origins are genetic or social. While this may be so in individual cases, many would argue that medical care can overcome social disadvantage, as is shown by the observations that the perinatal mortality rate may vary from one area to another by a factor of more than two and that good figures are reported from socially deprived parts of the country while the figures from areas with a well-provided population are sometimes poor.

There is still much that can be improved in the maternity services in Britain. The place of delivery remains an important issue, with one-fifth of women being delivered in general practitioner units, many of them in isolated parts of the country and with low bed occupancy. General practitioners are well aware that those who want to practise obstetrics need facilities for co-operation with their consultant colleagues and for continuing training. With modern monitoring techniques intrapartum stillbirth is now preventable, yet few units have adequate facilities to provide this level of surveillance.2 Clearly the relative shortage of doctors and midwives throughout the maternity services militates against any major improvement. For doctors, the embargo on expanding the training grades, in particular at the registrar grade, has made it impossible for many consultants to provide the adequate 24-hour cover necessary for good obstetric care. Morale among midwives is also low. Many units, particularly those in the inner cities, cannot obtain sufficient permanent staff and either function below their complement or have to rely on the unsatisfactory solution of filling gaps with agency midwives.

This state of affairs is due mainly to the disincentives of poor pay and conditions for midwives in the NHS. A newly qualified midwife gets the equivalent of the pay of a staff nurse on the general side, which she could have got without doing an extra year of training.

Though the dissolution of Parliament has stopped the work of Mrs Short’s committee, that need only be temporary. The committee can be reformed in the next Parliament regardless of the political party that wins the election, when it could quickly issue an authoritative report. The time and effort put into the preparation of evidence by professional bodies and its careful examination by the committee could be wasted—with potentially highly damaging effects on efforts to improve the outlook for the newborn in Britain.

Cocaine

The leaves of *Erythroxylum coca*, a shrub found in Bolivia and Peru, have been chewed for their stimulant and euphoric effects by South American Indians since at least the 6th century.1 When Francisco Pizarro returned from Peru to the Court of Spain in the 16th century he probably brought back coca leaves, but not until 1857 was cocaine, the active alkaloid, isolated. In 1884 Koller and Freud (the analyst) introduced cocaine into ophthalmology as a local anaesthetic, and in the same year Halstead produced the first nerve block with a local injection.2 3 There followed a period of enthusiasm for cocaine, both as a central stimulant and as a local anaesthetic, but by 1891 there had been 200 reports of systemic intoxication including 13 deaths attributable to the drug.4

1 British Medical Journal, 1978, 1, 1372.
3 Illingworth, R S, British Medical Journal, 1979, 1, 802.
4 Mallett, R, and Knox, S, Community Medicine, 1979, 1, 6.

---