Rituals in antenatal care

Consider women's psychosocial needs

EDITOR,—We welcome Philip Steer's call to discard outdated rituals in antenatal care and to explore more promising interventions.[1] A considerable body of evidence casts doubt on many of the procedures carried out in antenatal consultations; the work of Hall *et al* in Aberdeen[2] and comparative evidence from Europe[3] suggest that fewer antenatal visits may be acceptable. However, we would urge caution on two counts before the schedule of visits is changed. Firstly, although the experience in Aberdeen is reassuring, as is that of a trial in Zimbabwe (S P Munjanja, conference on the Royal College of Obstetricians and Gynaecologists and safe motherhood, 13-14 July 1992), there are no results from randomised controlled trials of different schedules of visits in Britain.

Perhaps more importantly, any proposed changes in the schedule of antenatal visits should be shown to meet women's psychosocial needs as well as to be clinically safe. Although trials of social support have not shown any great effects on traditional clinical outcomes, the evidence shows that "supported mothers are more likely . . . to feel 'in control' during pregnancy and postpartum, to be satisfied with their medical care, not to feel unhappy after the birth, to have partners who feel involved with the baby, to be breastfeeding, to report physical well-being and to have babies with fewer worrying health problems."[4] If the number of antenatal visits is reduced without these important measures being taken into account, benefits may be lost.

We are currently conducting a randomised controlled trial of a reduction in the number of antenatal visits for low risk women. We hope that this will provide helpful information about the clinical and psychosocial effectiveness of different schedules of visits.

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Women should understand the need for change

EDITOR,—Philip Steer puts forward reasoned arguments for changing the emphasis of antenatal care,[1] giving evidence of when many tests are less useful than our predecessors thought. Much of this has been known for a decade or two, yet still the patterns of antenatal care laid down by Janet Campbell in the 1920s for the poor of east London persist.

Many people have tried to break this pattern. At Queen Charlotte's Hospital in the early 1970s we tried to stop routine antenatal examinations in the relatively safe mid-trimester for women at low risk. Instead we substituted discussion groups for the women, with one doctor. This was done in the hope that, as they got to know each other and the doctor, the women would ask more questions and discuss any problems that they might not have wished to air previously. The experiment failed not through conservatism of the professionals but because of the women themselves. They thought that they had lost out on something. At the end of the discussion they would ask if they could have their blood pressure checked or abdomen palpated and so perpetuated the pattern of care. This is not an excuse for continuing traditional antenatal care but is one of the reasons why it has continued. Education takes generations, and the women themselves must understand the reason for change.

There is a completely different reason for not altering patterns of antenatal care too much at present. This is the growing concept that our predecessors concentrated too much on mothers with a high risk. Fetuses at high risk are often carried by mothers at high risk, but some are not. Although perinatal mortality rates have been reduced among mothers at high risk, this decline has not been seen, even proportionally, in mothers at low risk, often in the same population.

Modern antenatal care should therefore seek to identify fetuses at high risk. Such care would entail assessing the value of new techniques such as measurement of blood flow in the umbilical artery or uterine artery. This would mean seeing many pregnant women where such techniques were available. A review in Lothian and Borders in 1988-90 showed particularly that fetuses at high risk were those with intrauterine growth retardation (often not detected by conventional care) and those that went on to suffer an unexplained intrauterine death. If we are going to advance we must identify these fetuses in order to concentrate medical and midwifery activity on them rather than go on using the pattern of care that started 70 years ago and to which investigations were added as they came along. As well as providing the support and educational activities of antenatal care we must look specifically at those tests that may diagnose the high risk fetuses of low risk mothers, discarding tests that are less useful.

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Routine ultrasound scanning in pregnancy

EDITOR,—Justin C Konje and colleagues[1] point out some limitations of the meta-analysis done by Heiner C Bucher and Johannes G Schmidt.[2] They also point out that Neilson reached a different conclusion on whether routine ultrasound in early pregnancy generally reduces the incidence of induction of labour.[3] In their reply[4] Bucher and Schmidt say that the explanation for this discrepancy is the inclusion of the Helsinki trial[5] in their meta-analysis. I believe that Bucher and Schmidt should have paid more attention to the reservations of the authors of the Helsinki trial before they concluded that the pooled estimate of the meta-analysis showed no evidence that ultrasound reduces induction of labour.

The Helsinki trial included 58% of the women in the meta-analysis. Owing to the customary use of ultrasound among the participants in the Helsinki trial 77% of the control women had ultrasound examination(s) during pregnancy. The authors point out in the original paper that "the possibilities of revealing an effect in a controlled trial are less likely than when there is a sharper contrast between screening and selective use of ultrasound."[5] Bucher and Schmidt were also aware of this danger: "The use of ultrasonography in the control groups may have diluted a possible true effect of ultrasound screening."[2] However, they find this unlikely. I disagree and find it likely. Thus the report of no effect of routine ultrasound on induction of labour in the Helsinki trial and the meta-analysis may be due to the fact that almost all the control women had ultrasound scans anyway. My conclusion on the basis of the randomised controlled trials in the meta-analysis is that routine ultrasound reduces induction of labour in populations in which ultrasound scanning is not frequently performed.

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Routine postnatal examination

Pelvimetry is unnecessary . . .

EDITOR,—We agree with the main message contained in Tony Noble's editorial on the routine postnatal vaginal examination[1]; indeed we had already abandoned this practice. We take issue, however, with the point that *x* ray pelvimetry improves advice regarding the future mode of delivery after caesarean section. There is no evidence that pelvimetry is of benefit; Thubisi *et al* found that *x* ray pelvimetry reduced the vaginal delivery rate from 60% to 16%; that only 28% of those women thought to have an adequate pelvis achieved a vaginal delivery; and that 55% of the women who had vaginal deliveries in the control group would have had an unnecessary caesarean section had pelvimetry been performed antenatally.[2] *x* Ray pelvimetry as a test to predict future successful vaginal delivery was worse than chance. Thus study confirmed previous retrospective finding which found that 66% of women with an "inadequate" pelvis on pelvimetry subsequently delivered vaginally.[3]

Although cephalopelvic disproportion is often cited as the indication for caesarean section, more often the true indication is failure to progress in labour, or there is a relative disproportion due to

malposition. Repeated studies have found that over 70% of women with cephalopelvic disproportion delivered vaginally in subsequent pregnancies.[4,5] In addition, 31% of those women achieving vaginal delivery after caesarean section for cephalopelvic disproportion had larger babies than the one delivered by caesarean section.[5]

x Ray pelvimetry does not prevent scar rupture in a subsequent labour,[1,5] nor is there any benefit with regard to perinatal mortality. Although computed tomography of the pelvis has not been subjected to large clinical trials, there is no logical reason to suppose that it will be any more effective than conventional *x* ray pelvimetry in predicting the ability of a woman to have a future safe vaginal delivery.

x Ray pelvimetry is not routinely indicated postnatally after a first caesarean section. It is an unnecessary investigation with no prognostic significance for delivery in subsequent pregnancies and will result in a needless increase in the already high rate of caesarean section.

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. . . forget it

EDITOR,—We agree with Philip Steer[1] and Tony Noble[2] in their pleas for continence in obstetric practice. They echo our recent calls for routine obstetric practices that have been shown to be of no value to be abandoned.[3,4] If obstetricians want to be listened to, however, they should practise what they preach.

Noble suggests arranging "*x* ray pelvimetry or computed tomography of the pelvis to improve advice regarding the desirable mode of any future deliveries" for women after their first caesarean section. This is another obstetric ritual that has been shown by both retrospective and prospective[5] randomised controlled trials to be of no value in predicting safe vaginal delivery after caesarean section. Furthermore, patients having *x* ray pelvimetry had a higher rate of repeat caesarean section with no associated improvement in the outcome. Computed tomography and magnetic resonance imaging have also been used for pelvimetry. Surely the fundamental issue here is not how to do it but rather "should we do it?" The evidence suggests that the same advice given regarding routine six week postnatal vaginal examination should apply to pelvimetry; forget it.

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GPs well placed to recognise postnatal depression

EDITOR,—Tony Noble pleads for the focus of the postnatal check up to be moved from pelvic examination to consideration of "more general disorders."[1] The role of general practitioners in prenatal and postnatal care is under threat, and a clear exposition of its importance is overdue. Of particular relevance is postnatal depression.

Rarely encountered by obstetricians, postnatal depression is poorly covered in specialist textbooks and may not feature in teaching. Yet it has serious consequences for a tenth of women and their children. Insidious of onset and manifesting itself differently from other depressions, it may not be easily recognised. The woman feels inadequate, worthless, and a failure in her new task. Confessing such feelings, when she should be joyous, is difficult and eased by access to a practitioner whom she expects to be approachable and supportive. The general practitioner is uniquely placed. Providing antenatal care creates rapport and appreciation of the woman's personality; postnatal changes may thus be more readily identified. The midwife is likely to have stopped visiting before the depression is evident, and the health visitor has no experience of the woman's personality and may be distracted by issues of child development.

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1 Noble T. The routine six week postnatal vaginal examination. *BMJ* 1993;**307**:698. (18 September.)

Do GPs need to visit well mothers at home?

EDITOR,—I agree with Tony Noble that vaginal examinations at the postnatal visit at six weeks should be limited to women with specific indications.[1] I should like to make a similar point about home visits after normal deliveries. General practitioners may claim a fee for each home visit (up to a maximum of five in the first 14 days after delivery). Unless there is a specific indication, is it necessary to have a routine home visit after a normal delivery of a normal, healthy baby?

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1 Noble T. The routine six week postnatal vaginal examination. *BMJ* 1993;**307**:698. (18 September.)

Other examinations should be abandoned

EDITOR,—I agree with Tony Noble that routine vaginal examinations are unnecessary as part of the postnatal examination.[1] Most postnatal examinations, rightly, are carried out in general practice. General practitioners are bound by their terms and conditions of service. The "red book" states that "the practitioner is required to certify that in providing the services he or she has regard to, and has been guided by, modern authoritative medical opinion." What now constitutes authoritative medical opinion?

Many of the other intrusive and embarrassing examinations that women are subjected to are probably unnecessary. Why, for instance, should we examine the breasts of teenagers when prescribing a contraceptive pill? How many teenagers develop breast cancer? Benign breast disease is usually symptomatic. If it remains asymptomatic even when teenagers are taking the pill then surely it is not important.

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Assessment of elderly people in hospital

Use clinically relevant assessment tools

EDITOR,—As coordinators of a regional audit project in geriatric medicine we wish to report our findings and to comment on Rebecca B Dunn and P A Lewis's findings that compliance with guidelines for assessment was poor among geriatricians in Wessex.[1] Our objective was to compare one outcome measure (institutionalisation) in five districts in the region.

When a patient was discharged his or her consultant completed a form that indicated, among other information, whether the patient was transferred for permanent care to a residential home, a nursing home, or an NHS continuing care unit; the documentation was then sent to the coordinating centre. There patients' details were matched with data collected separately for each in patient stay and held on the regional district information system. We found that all forms returned to the centre contained information on the patient's destination on discharge. For each centre between 70% and 98% completed consultant episodes recorded on the district information system could be matched to forms completed by consultants.

Our experience of planning and executing the project over six months gives rise to several observations. Firstly, the assessment tool and when it is used must be clinically relevant. We therefore question the value of measuring the Barthel activities of daily living scores on admission for acutely ill elderly people, who may be attached to monitors or intravenous drips. For our project a supervisory group included one representative from each participating hospital; we found that regular feedback was essential to sustain interest. Peer pressure from centres that achieved a high proportion of matches between completed consultant episodes and forms resulted in improved performance in the others. We hope for an even higher proportion of matches in our second project, which will monitor the effects of the new legislation on community care. Further details of the method and results of our project may be obtained from us.

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1 Dunn RB, Lewis PA. Compliance with standardised assessment scales for elderly people among consultant geriatricians in Wessex. *BMJ* 1993;**307**:606. (4 September.)

Assessment scales unevaluated

EDITOR,—Rebecca B Dunn and P A Lewis report that voluntary use of standardised assessment scales recommended by the Royal College of Physicians and British Geriatrics Society is low, with the abbreviated mental test score and the Barthel index being recorded on admission and discharge for only 190 of 958 consecutive patients.[1] Though it may be useful to measure both scores on admission as part of systematic history taking because they have proved predictive value,[2] repeat measurements are of more dubious value and may lead to the use of inappropriate measure of outcome, such as the increase in the Barthel index per week of admission.[3,4]

Use of these standardised scales should be supported by evidence that the resultant information is associated with better outcomes (for example, survival or reduced disability) or better processes of care (for example, shorter stays in hospital, more comprehensive management, or improved diagnosis of treatable disease). A randomised controlled trial in the United States showed that use of scales that assessed function