Confidential enquiry into maternal mortality

Sir,

Professor Drife must be congratulated for his careful resume (p.156) of the latest Maternal Mortality report, highlighting the major causes of maternal death in this country. The first such report was published 40 years ago (1954–56) when the number of births in England and Wales was 2.1 million, as opposed to the 1.8 million now. Forty years ago there were 1 480 deaths, as opposed to the 376 reported in 1998. Professor Drife gives an excellent summary of the causes and recommendations of the Committee, and is indeed lighthanded in his criticism.

Pulmonary embolus is now top of the list of causes of death, 46 deaths being recorded. Forty years ago it was fourth, following toxaemia, haemorrhage and abortion. It is traditionally considered to follow caesarean section, but caesarean section was traditionally meant to follow long, arduous, dehydrating, potentially infected labours.

With the rising caesarean section rates throughout the West, the maternal mortality and morbidity rates following elective surgery in healthy low-risk mothers should be audited separately from other groups. Both Professor Drife and the Committee highlight the need for all units to have guidelines for the management of other potential complications, thromboprophylaxis, massive haemorrhage and eclampsia. Perhaps both should have highlighted the need for these guidelines to be idiot-proof, in your face, openly displayed through all clinical areas and as commonly put into practice as giving mothers a cup of tea after delivery.

Our anaesthetic colleagues, by simply moving more highly trained anaesthetists into the labour ward environment, have presided over a dramatic fall in deaths from anaesthesia-related complications. Logic dictates that if obstetricians do likewise, the benefits for all concerned will become evident.

Childbirth is now considered by many in the community, both lay and medical, to be a very safe and natural process. In fact, it is considered so safe by many that we can safely turn the clock back. However, there have been no major design-feature changes in women and the process of parturition in the last 40 years and there is much evidence to suggest that if we turn the clock back, we will indeed turn the clock back.

Nature, combined with the dedication and hard work of the midwives, GPs and hospital doctors, who watch over our 1.8 million women on 15 million occasions over 3 years, should be congratulated. But it is not a time for complacency.

James C Dorman
Director of Fetomaternal Medicine
The Royal Maternity Hospital
Belfast BT12 6BA

Sir,

Professor Drife's editorial highlights the devastating problem of maternal death in the UK. There is no room for complacency. A most worrying trend is the dramatic increase in deaths from pulmonary embolism. The enquiry suggests that many of these women die, not despite the effort of doctors, but rather because of their failings. In report after report over the years, clearly identifiable risk factors have been illustrated. These can be identified in a basic medical history, cursory clinical examination and an enquiry of a past or family history of thrombotic events and/or thrombophilia. It is imperative that the message with regard to these risk-factors and prophylaxis is translated into obstetric practice. Furthermore, the use of objective testing has also been emphasized.

Despite these worrying concerns with regard to pulmonary thromboembolism, there are undoubtedly some welcome improvements. Deaths associated with anaesthesia continue to fall, a testament to improved obstetric anaesthetic services. There were reductions in deaths from obstetric haemorrhage and cerebral vascular accidents in women suffering from hypertension, suggesting better management of major haemorrhage and control of blood pressure respectively. However, this was, to some extent, offset by increasing deaths associated with hypertension resulting from multi-organ failure.

Again, clearly identifiable deficiencies in medical care were noted in many of these cases, deficiencies which could be overcome by management in appropriate units according to established protocols with good anaesthetic and obstetric support. Medical disorders are also of importance.

Although collectively they form a wide variety of conditions, it is noteworthy that epilepsy was associated with no fewer than 19 maternal deaths in the last triennium. Given that this is a disorder affecting around 2% of the female population, then there should be reasonable experience of dealing with epilepsy during pregnancy. Medical disorders including epilepsy should, ideally, be managed through specialist medical clinics if optimal control of the medical condition is to be achieved. The Enquiry also looked, in more depth than previously, at the area of psychiatric problems and domestic violence, identifying serious problems in women's health, which may not have been immediately apparent to obstetricians and midwives.

The Confidential Enquiry represents an important component of clinical self-audit. Looking to the future, it is likely that more can be learned from an assessment of the frequency, severity and underlying factors in non-fatal critical incidents rather than deaths alone; a topical subject with the implementation of clinical governance.

IA Greer
Muirhead Professor and Head of Department
Department of Obstetrics and Gynaecology
University of Glasgow
Glasgow G31 2ER

Physician-assisted suicide: the debate continues

Sir,

Unlike Professor Ilora Finlay (Vol 60(1), 1999, p. 4), I hope that physician-assisted suicide will become decriminalized soon and eventually legalized. Incidentally, I believe that palliative care is more effective if patients are reassured that they can have this option of physician-assisted dying.

At present, physician-assisted suicide is legal in Oregon and is decriminalized in The Netherlands and Switzerland: are we, in this country, so different from the Dutch, the Swiss and the residents of Oregon?

In her article, I note that Dr. Finlay writes that 'Depression occurs in about 20% of patients with advanced cancer...' If I had 'advanced cancer', I would expect to be very depressed, and surely most readers of *Hospital Medicine* would feel the same way?

Michael Irwin
Chairman
Doctors for Assisted Dying
2 Old Brompton Road
London SW7 3DQ

Sir,

Dr Irwin states his belief, but it is clear evidence that is required. Evidence from Holland, where euthanasia has not been prosecuted since 1984, suggests subtle changes in society and expectations towards euthanasia without being offered comprehensive palliative care. Comprehensive palliative care in Holland is growing rapidly in response to the demand from general practitioners to be better educated in ways to cope with terminally ill patients, other than needing to resort to euthanasia.

The diagnosis of depression is important, as it is a treatable condition which must be distinguished from appropriate sadness. Indeed, it would be strange if someone with advanced cancer did not feel extremely low in spirits, but clinical depression is in part reversible with appropriate antidepressant treatment.

Dr Irwin questions the difference between the UK and other countries. In the UK we have a comprehensive NHS with its financial stringencies, but do not have the overt rationing debate that occurred in Oregon. Neither do we have the societal culture of trilingual Switzerland or of the Netherlands. It is important for all direct and indirect effects to be considered if the current protective role of the law, which prohibits killing, is to be altered.

Ilora Finlay
Professor of Palliative Medicine
University of Wales College of Medicine
Medical Director
Marie Curie Centre
Penarth
Vale of Glamorgan CF64 3YR