NEW BOOKS

ACTIVE MANAGEMENT OF LABOUR. CLINICS IN OBSTETRICS AND GYNAECOLOGY. SUPPLEMENT 1

Kieran O'Driscoll and Declan Meagher

W. B. Saunders
London (1980)
192 pages. Price £6.95

The National Maternity Hospital in Dublin claims the highest annual number of births in the British Isles. The system of administration there is probably unique in that decisions regarding policies of obstetric management are in the hands of a single 'Master' for a period of seven years. This volume describes in detail the doctrinal approach applied by two successive Masters (the co-authors) from 1963 to 1976 and from which the title is derived. The book is divided into three parts: the principles on which their prescribed régime depends, the practicalities of its application and the results achieved.

Their precepts depend on a number of propositions:

1. Primigravidae and multigravidae in labour behave in very different ways: in the primigravida, delay in the first stage is usually the result of inefficient uterine action whereas, in the parous woman, uterine action is usually efficient and delay more often the result of obstruction or malpresentation.
2. The primigravid uterus is virtually immune to rupture.
3. Cephalopelvic disproportion is very uncommon and can rarely be diagnosed prospectively.
4. Instrumental delivery affords the greatest risk of damage to the infant; it is much more preferable for the fetus to be propelled from the uterus rather than extracted from it.
5. Duration of labour is the main factor influencing a woman's subsequent attitude to her experience of childbirth.

In essence, their treatise is concerned with the management of the prototype woman in labour (the primigravida with a single fetus presenting by the vertex) although the significance of variations from this norm and the consequent implications are not ignored.

The methods described have well-defined criteria, and efficient uterine action is the cardinal objective. Again, certain principles are mandatory:

1. A positive diagnosis of onset of labour must be made.
2. The membranes should be ruptured at an early stage (the character of the liquor, incidentally, gives a reliable indication of the condition of the fetus).
3. Progress of labour is monitored by frequent assessment of cervical dilatation and recorded on a simple partograph developed from Philpott's original concept.
4. If progress in the first stage of labour lags behind the expected norm, augmentation with intravenous oxytocin is instituted without hesitation according to a standard regimen.
5. Delay in the second stage is as likely (in the primigravida) to be due to inefficient uterine action as to mechanical factors. That being so, augmentation with oxytocin is more logical than instrumental delivery.

Nor is the relationship with the patient overlooked. A stated objective of active management is to combine medical efficiency with human compassion *(cum scientia caritas?)*. A contract therefore is entered into with each patient. Firstly, she will have a personal nurse throughout her labour and secondly, the duration of labour will not be permitted to exceed 12 hours. Indeed, after the initial assessments to establish the pattern evolving, it should be possible to predict the time of delivery within an hour.

The chain of command in supervision in the labour wards is stressed; next to the Master, the sister-in-charge stands in supreme authority and has primary responsibility for decision-making. Staff nurses act as her assistants and student nurses adopt the role of personal attendant to each woman in labour. A senior registrar must review each woman every four hours and agree any deviation from standard procedure with the sister-in-charge. Junior medical staff have an executive role but are not involved in autonomous decision-making. They are regarded as postgraduate students!

The results from this unit are impressive. The average duration of labour in primigravidae is six hours. Fifty per cent receive no analgesia (attributed to high morale and antenatal education). The quoted incidence of cephalopelvic disproportion is one in 250 cases. The rates for forceps and caesarean delivery are 10 and 5 per cent respectively. The induction rate is about 10 per cent and is achieved by simple amniotomy in most cases. Regional analgesia is used in only 5 per cent of patients.

This then is the account of an impressive, albeit somewhat rigid, régime for the management of women in labour that has attracted world-wide interest and has been adopted in whole or in part by many other centres. So basic and logical are its precepts that it should be mandatory reading for every doctor engaged in intranatal care. A seemingly overwhelming case is made for relegation of more traditional methods of management such as 'watchful expectancy' in the first stage of labour, which culminate so often in radical intervention in the second. The authors have the grace to confess, however, that pressure on the hospital delivery suite and the need for strict limitation of duration of labour was an important factor in the development of their methods. With 8,500 deliveries per annum and only five delivery rooms, simple calculation will show that the average duration of occupation for each room must not be more than five hours per patient. Units more fortunately placed in this respect could well apply these principles without necessarily being governed by such rigid deadlines.

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RETROLENTAL FIBROPLASIA. A MODERN PARABLE

William A. Silverman

Grune and Stratton
London (1981)
246 pages. Price £13.20

This is an as yet little-known minor classic not to be missed. Like other doctors who worked in the 1950s, I knew the horror of the RLF story, but regarded it as a closed chapter in our long progress from greater to lesser degrees of ignorance. Dr Silverman, an exceptionally caring and thoughtful New York haematologist, not only retells the whole story as a participant and protagonist, but, with remarkable honesty, applies hindsight with compassion for patients, parents and colleagues. Un-

like later generations of American medical authors, he has something to say and says it very well indeed.

The sub-title, *A Modern Parable,* is apt. This concrete, specific account of the ethics of clinical decision-making and research is worth more than the entire product of our recently burgeoning medical ethics industry, with its abstract, pretentious and usually irrelevant hand-wringing on the outskirts of medicine. No teaching practice should be without it, every general practitioner and trainee should read it.

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BOOKS FOR PATIENTS

OVERCOMING ARTHRITIS

Dr Frank Dudley Hart

Martin Dunitz
London (1981)
152 pages. £2.50

This is one of the best books for patients that we have seen for some time. The pictures are first class and have been chosen with great care to illustrate the many practical tips on coping with arthritis in everyday life. The writing is straightforward and sensibly optimistic, and through the book there is great emphasis on how to live with these chronic and incurable diseases. The price is very reasonable for such a high-class production.

PSORIASIS. A GUIDE TO ONE OF THE COMMONEST SKIN DISEASES

R. Marks

Dunitz
London (1981)
107 pages. Price £2.50

This series is rapidly establishing itself as the best in the field, the books being invariably well written and attractively produced. The tone of this one is realistic yet encouraging, and amply justifies the title 'Positive Health Guide'. It can be unreservedly recommended to patients, and contains many good ideas that will probably not be known to doctors and nurses in general practice. In these inflationary times we just have to get used to the idea that a popular paperback can cost £2.50 and yet be good value for money.

THE REAL FOOD GUIDE. VOL. I, FRESH FRUIT AND VEGETABLES. VOL. II, PULSES, GRAINS AND SEEDS

Cass McCallum

Richard Drew Publishing Ltd,
Edinburgh (1981)
210, 196 pages. Price £2.95 each

How important is good nutrition to good health? What has medicine lost since British doctors virtually ceased to offer dietary advice as the main method of managing illness? Are our patients wiser than we are in asking for advice so much more often than we give it? Recent evidence suggests that nutritional factors (folic acid and vitamins) may be important in the genesis of fetal malformations, and in his James Mackenzie lecture in 1978, Dr W. W. Yellowlees presented a powerful case for the effect of good food on health.

The question is, how do doctors use the new evidence, and the new appraisals of old evidence? As scientists, we are not attracted by what seem to be the wild claims and prejudices of cranks and faddists, and the results of nutritional experiments are seldom presented in medical journals. What, then, should our sources of information be? These two books contain a great deal to help us: they tell us about fruit, vegetables, pulses, seeds and grains in terms of their food value, and how best to preserve this in storage and cooking. There is little purely scientific material which duplicates medical textbooks, but about a quarter of each volume contains recipes that are little different from those in many other wholefood cookery books. Therein lies the attraction of any new recipe book: we all get bored to some extent by the same food cooked in the same way, and a fresh look at old recipes is hard to resist. Doctors who think that the move to wholefood is for freaks alone will be pleasantly surprised if they buy these books and learn to cook from them. They can be highly recommended to patients.

YOU CAN DRINK AND STAY HEALTHY

Dr Robert Linn

Sphere Books Ltd
London (1981)
179 pages. Price £1.25

Well worth looking at in a bookshop to see if it is the kind of thing that you would want to recommend to young people, to patients asking for information, or even to someone with a drinking problem who seems to be in the frame of mind to follow advice. Written for a US audience, but perfectly applicable to the UK.