Place of birth and perinatal mortality

Sir,

Marjorie Tew (August *Journal,* pp. 390-394) uses the single yardstick of perinatal mortality to suggest that birth at home is safer than birth in hospital. She claims that her findings from the perinatal surveys of 1958 and 1970 are still valid today and goes on to suggest that the benefit of advances such as fetal monitoring and Caesarean section has not been evaluated. These deceptive claims will understandably alarm the lay public and the vocal anti-obstetric minority.

Modern obstetricians do not regard the avoidance of perinatal death as their only aim but are also concerned to avoid birth asphyxia and subsequent handicap and to make childbirth safe and rewarding for the mother. It has been shown that continuous fetal heart rate monitoring and fetal scalp sampling can reduce perinatal mortality by the elimination of intrapartum stillbirths; they can also reduce first week neonatal deaths.[1] This holds true for both high-risk and low-risk labours.[2] Other factors are no doubt important, such as the use of oxytocin in the active management of labour, which prevents long labours, reduces the incidence of forceps deliveries and Caesarean sections and is therefore of benefit to both mother and child.[3]

Mrs Tew's paper does not mention maternal mortality but it is important to remember that healthy women still die from postpartum haemorrhage. Since only 25% of such events are predictable,[4] more home births will mean more dead mothers.

The misuse of statistics should not lead to a call for more home births. Obstetric care can and will be improved and maternity hospitals should become pleasant, welcoming places where pregnant women will go in the knowledge that they are the safest places for themselves and their babies.

P. HOGSTON

Department of Obstetrics and Gynaecology
Princess Anne Hospital
Coxford Road
Southampton SO9 4HA

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Sir,

The studies referred to by Mr Hogston fall short of being impartial evaluations of fetal monitoring and the use of oxytocin to induce or accelerate labour. They do not report the results of randomized control trials or comparisons of groups matched for pre-delivery risk and for other aspects of intranatal care. Some of these studies compare results in years when most births were monitored with those in earlier years without monitoring, ignoring the possibility that other factors had also changed and could account for the observed decrease in perinatal mortality. Some found significantly lower mortality in monitored groups compared with contemporaneous unmonitored groups, where the pre-delivery risk was probably lower but where other aspects of obstetric management in hospital may have been different. None compared the results of using these techniques as constituents of high-technology management with the results of not using them in low-technology care. The use of oxytocin has been found to be associated with a higher incidence of fetal distress,[1] so that obstetric management itself tends to generate the need for fetal monitoring.

I am assured that domiciliary midwives, if equipped, would be competent to administer blood transfusions, but the need would be less in spontaneous, normal labours, for postpartum haemorrhage as the study by Hall and colleagues confirms,[1] is more likely to follow induction and the use of oxytocin.[2]

As for obstetricians' concern to avoid birth asphyxia, it is pertinent to note that while the perinatal mortality rate (all causes) fell by 29% between 1979 and 1983, for intrauterine hypoxia and birth asphyxia (ICD 768) it fell by only 10%.[3]

MARJORIE TEW

Department of Surgery (Orthopaedics)
University Hospital
Queens Medical Centre
Clifton Boulevard
Nottingham NG7 2UH

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Sir,

I was very interested to read the article by Marjorie Tew (August *Journal,* pp. 390-394), but I would take issue with her on several points.

I really cannot accept that anything other than analysis of results by intended place of delivery really answers the question as to which is the safest place for confinement. The largest group of babies which die in the perinatal period are those which weigh 2.50 kg or less, and any patient going into labour prematurely or with a known growth retarded infant will be transferred for hospital delivery. Mrs Tew does accept the point about known intrauterine deaths being transferred to hospitals, but I think that if the premature babies were added (most of which are the result of spontaneous onset of premature labour) her statistics would look very different. The only easy way to overcome these difficulties is by looking at the outcome related to original booking rather than to final place of delivery.

As far as scoring is concerned, all the article proves is that scoring does not work. Certainly, we have very strict criteria for booking at the general practitioner unit here and, despite this, 50% of booked normal births are ultimately delivered at the consultant unit. Looking at outcome by intended place of delivery, the perinatal mortality for patients originally booked for the general practitioner unit was notably higher than that for patients actually delivered at the consultant unit. Similarly, I do not accept the assumptions made in arriving at the standardized perinatal mortality rates (Appendix 1, p.393).

While it is very healthy to question so-called advances in care — there was undoubtedly too much of a swing in the direction of induction at one stage — I think it is equally dangerous to go to the other extreme and give the general public the impression that home confinement is safer than hospital confinement. This only results in patients who are adverse to hospital for a variety of reasons insisting on home confinement, sometimes with a fatal outcome, not only for the baby, but also for the mother.

P. WATNEY

Sandwell Health Authority
Lyndon
West Bromwich
West Midlands B71 4HJ

Sir,

It may or not be true, as asserted by Marjorie Tew (August *Journal,* pp.390-394), that 'perinatal mortality is significantly higher in consultant obstetric hospitals than in general practitioner maternity units or at home', but from her data, based on the 1970 British births survey, there is no means of knowing.

We would like to raise for debate some points arising from the paper which we feel are misleading, to add other points which were omitted, and to introduce more recent data, especially from the health district in which she and both of us live.