general practice ultrasound in predicting fetal survival to the twentieth week of pregnancy, following early pregnancy bleeding. The paper would have been more useful to practising GPs if the predictive value of such ultrasound had been given by age at the first bleed. Indeed, we do not even know the distribution of gestations at which bleeding occurred. Were 90% of women less than 12 weeks gestation? Were half of them over 16? Secondly, once women had bled, were they only referred if there was an absence of fetal heart sounds after using only the ear trumpet, or after absence of sounds found using a sonic aid? This is a crucial point because once the fetal heart has been heard using a sonic aid after an early pregnancy bleed, there can be little point in following it up with an ultrasound as advocated in this paper.

More importantly, the whole paper may be based on false assumptions. In the 'Discussion', the authors state that, before the development of ultrasound scanning, 'bed rest was frequently advised for women with viable and non-viable pregnancies without discrimination'. Therefore, the implication is that, if a scan is done, one could avoid unnecessary bed rest. The flaw in this argument is that there is no evidence that bed rest makes any difference to threatened miscarriage. Therefore, it should not be advocated at all as a routine. Women should be told that there is no evidence that it will make any difference to the outcome of the pregnancy and then choose whether they wish to rest or not.

The other potentially falacious reason for using ultrasound in this situation is that, if the fetus is not alive, then 'appropriate arrangements can be made at an early stage in the knowledge that miscarriage is inevitable'. The implication here is that an ERPC could be arranged without unnecessary delay. This assumes that ERPC is of benefit to women with inevitable or incomplete miscarriage. This may well not be the case. A recent Swedish trial found that ERPC versus expectant management did not improve outcome and may have increased infection.[1] Indeed, the Dutch College of General Practitioners[2] recommends that a scan is delayed for up to 2 weeks with no increased in complications. Such a waiting policy will avoid most ERPCs at present performed in the UK. However, unlike Dutch women, British women may not accept such a delay. Certainly, the authors do not discuss this point.

The authors finally suggest that 'further studies are needed to compare the different ways of delivering a prompt, diagnostic ultrasound service for all women with bleeding in early pregnancy'. The real question surely is whether an ultrasound is necessary at all? Research is required into women's views towards the use of ultrasound in early pregnancy bleeding, and into the best way of managing confirmed, inevitable or incomplete miscarriage.

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Guidance for GPs for Maternity Medical Services

Sir,

I am writing to express my concern over the Guidance for GPs for Maternity Medical Services, which was distributed by the GMSC in November 1995.

The document claims to try to protect women who choose GP-managed obstetric care, whether it be a home delivery, a GP unit or GP/consultant integrated unit, from suffering as a result of being attended by a GP who does not possess specialist obstetric skills by recommending that no GP should undertake intrapartum care unless he or she possesses such skills.

If the recommendations in this report are accepted, then women who wish to exercise their right to choose a home birth are much less likely than they are at present to be able to find a GP willing to attend, GP units will cease to exist, and midwives, who have no choice but to attend home births, will find their workload increasing.

Most women are aware that their GP usually does not have specialist obstetric skills, and it is reasonable to presume that they take this into account when making a decision about their delivery.

To recommend that a GP should withdraw his or her services from a patient, and thereby, reduce the range of delivery options available, when both are fully aware of what level of skill the GP can offer, is to act in a way which is contrary to the stated aim of *Changing Childbirth.*

If I had a patient with ischaemic heart disease who declined the offer of a consultation with a cardiologist, should I then refuse to treat her on the grounds that from then on I might expect my treatment of her to be judged by different and higher standards?

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Postnatal sexual health

Sir,

There is a widespread clinical impression that the period following childbirth is a common time for the onset of sexual problems,[1] and the NCT-commissioned study supports this view.[2]

Barret and Victor[2] suggest that GPs can begin to address the problem by asking simple direct questions, and in our experience, we fully endorse this. However, we think that GPs can do more than inform women of the negative effect that breast feeding may have on libido.

Childbirth, though a single event, is associated with enormous life changes that affect a couple not just for months but for years afterwards. The main contributing factors are hormonal changes, physical changes including intrapartum trauma, emotional and psychological changes in the woman and the man, and a significant change to the couple dynamics in the case of the first child or family dynamics for subsequent children.

Studies on how couples cope with the transition to parenthood have generally shown this to be experienced as a crisis,[3] and that children have a negative effect on their parents' relationship.[4] Thus, the sexual problems that present to clinicians may just be markers of dysfunctional relationships.

We believe that the majority of sexual problems need to be treated within the context of the relationship. Many heterosexual relationships depend on sexual communication as the major channel through which couples share time, thoughts and emotions. When this intimate contact declines because of disinterest, exhaustion or both, emotional distance develops that makes meaningful talk a little harder than it used to be. There is often a reduction in the intimacy-promoting activities that subtly lubricate the wheels of communication, such as nights out, time alone together and sex.

General practitioners, health visitors, midwives and other health professionals who have contact with women (and couples) during pregnancy and the postnatal period would do well to consider the difficulties couples face, and be able to discuss not only the hormonal and physical changes, but the relationship changes as well.