

### **A Bob Both Ways?**

THE NEW ZEALAND SOCIETY of Anaesthetists (NZSA) is disappointed at the lack of balance portrayed in the article *A Failure to Deliver*. The NZSA has previously commented on the quality of service at the margins but it is all too easy for the media to point the finger at the few who work at the margins of practice and draw the bow across the whole service. All this does is further demoralise a qualified professional workforce working hard to provide a national maternity service that meets the majority of women's and babies' needs. Doctors and midwives are not inured to personal stories but they are committed to the model of care we have in New Zealand.

It is fair to say anaesthetists have a jaundiced view of obstetric practice and we do not accept that maternity care is always a normal and low-risk activity. The anaesthetist's view of obstetrics is dominated by the fact we are not involved with natural births and are frequently called into to provide emergency and life-saving care. Anaesthesia occupies a unique position in helping both obstetricians and midwives care for women ranging from epidural pain relief to obstetric emergencies.

While we support the service provided by our midwifery colleagues and value the fact they are trained in "normal" birth and provide good care to the vast majority of pregnant women, we continue to advocate a mandatory postgraduate internship that would allow for further experience in the management of the abnormal in a hospital environment where communication skills and relationships with medical colleagues and tertiary-care

midwives could be fostered.

Doctors and midwives know from research that communication is at the heart of good maternity care and when failures in the system do occur, and they are very sad for all concerned, often this is because of poor communication.

The figures presented in the article lack a sense of proportion. Some 60,000-65,000 live births are recorded each year in New Zealand with some 650 stillbirths recorded annually. Even the richest countries record a one per cent stillbirth rate, which is consistent with our experience. The Perinatal and Maternal Mortality Review Committee (PMMRC) and the Australasian Maternal Obstetric Surveillance System (AMOSS) provide opportunities for robust data collection and current analysis. Health professionals are focused on improving the system, on sharing information, recording morbidity data and learning from poor outcomes. Drawing inferences from a few tragic cases erodes the confidence of women in their lead maternity carer and the system as a whole.

The PMMRC has not identified systemic failures in the maternity system. In order to address problems at the margin, we need sound information on which to base recommendations and to work collaboratively to improve the system we already have. An informed, patient-centred approach by all involved in the care of the mother and baby will result in better outcomes for all.

**Dr Rob Carpenter, president, New Zealand Society of Anaesthetists**