



Obstetric perspectives: quality within choice

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It is heartening to see a collection of articles in the current issue of the *Journal*, which illustrate the diversity of healthcare areas that interface with the provision of services to pregnant women.

Much emphasis has been given in the rearrangement of provision of antenatal care in New Zealand to a central tenement of maternal choice. Unfortunately, efforts together with the necessary funding to ensure that such a service is assessed by clinical audit have been slower to follow.

The situation with regard to data collection has certainly improved in recent years in New Zealand, with 2004 seeing the publication of the third 'Annual Report on Maternity' presenting collated maternity and new-born information.¹ However the data presented within this is very narrow, and is limited to minimal data sets such as overall caesarean section (CS) rates with only one sub analysis performed to distinguish elective versus acute surgery. More in-depth reviews, such as those published within this issue of the *Journal*, are greatly needed, to obtain a wider vision of the type and quality of care delivered to pregnant women; caesarean section rates (in themselves) do not reflect this.

Sangalli and Guidera's (URL: <http://www.nzma.org.nz/journal/117-1206/1184>) careful in-depth analysis of caesarean section in term nulliparous women (full-term pregnant women expecting their first child), undertaken in Wellington during 2001, highlights some important points, which are examples of areas that could lead to review of practice. For example, it is interesting to note that the majority of elective caesarean sections were performed for a breech presentation, with an attempt at external cephalic version prior to this in only one-third of women. This information has the potential of leading to a review of practice and provision of dedicated services such as external cephalic version, with full information and availability to all women.²

It is reassuring that the number of caesarean sections performed for maternal request at that time was very low and it would be interesting to view the trend of this over time. It is the suggestion from other countries such as the United Kingdom, that this component is likely to remain relatively low. Obstetricians locally have had some legal support that this is not a request they are obliged to respond to.

All centres should audit detailed maternity and perinatal outcomes, and indeed many centres do so; however the data collection to allow this should occur in a standardised way throughout New Zealand. This would allow for analysis of national trends and comparisons between centres adjusted for casemix; thus providing a basis for benchmarking.^{3,4}

Two further studies in this issue of the *Journal*, relating to smoking (Butler et al; URL: <http://www.nzma.org.nz/journal/117-1206/1171>) and genetic testing (Morgan et al; <http://www.nzma.org.nz/journal/117-1206/1178>), highlight that women also need

care prior to pregnancy to optimise the potential outcomes for themselves and their offspring.

Prepregnancy counselling is the ideal time for preventive medicine in a wide range of areas. General practitioners (GPs) are in a position to meet with possible parturients prior to conception, and are more likely to be aware of the broader family health care issues. It is the general practitioner who is most likely to facilitate appropriate genetic or medical investigation/referral prior to the onset of pregnancy. This forward planning enables information to be available so that prenatal diagnostic testing options are available to women, if they wish to access them, and allows for optimisation of certain medical conditions, such as diabetes, prior to (and in) early pregnancy.

The figures in relation to the incidence of smoking in pregnancy and the poor cessation rates in mothers of a Pacific birth cohort are echoed in what data we do have available across other ethnicity's in pregnant women in New Zealand.⁵ The deleterious effects of smoking on pregnancy are well recognised. Current estimates are that 1 in 3 pregnancies are exposed to smoking, however there is the potential to aid smoking cessation leading up to and during pregnancy, and certainly initial figures from the *Smokechange* programme are very encouraging with up to one-third of women becoming smokefree.^{6,7}

We can only hope that by largely excluding general practitioners from antenatal and intrapartum care that they have not been alienated from contributing the medical expertise, education, and referral base from which to help women prepare for pregnancy in a complementary manner to the subsequent midwifery and obstetric components of maternity services.

In conclusion, women within New Zealand should be able to have a high standard of healthcare within pregnancy, particularly with the availability of an excellent GP service, and the funded one-to-one care during maternity, with lead maternity carers from midwifery and medical backgrounds linking together. A comprehensive national perinatal database has long been called for to provide the data to inform health practitioners and the public on maternal and perinatal outcome.⁸

This month saw the publication of the UK triennial maternal mortality report.⁹ Obstetricians within that country, and internationally, will look to that publication to learn the lessons from these tragic outcomes and to incorporate the recommendations ensuing from their analysis into their clinical policies and practice. Neither mortality statistics (the most basic statistic to assess quality of care) or markers of morbidity which may be a more robust marker of quality of care are satisfactorily collated within New Zealand at present.

This data collection must be comprehensive, and to occur it will require adequate funding. Similarly, we will only achieve the best outcomes for women and their babies by accessing the strengths of all potential relevant healthcare workers involved in the provision of maternity care. .

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