infant
for neonatal and paediatric healthcare professionals

Improving neonatal and maternal health

Sometime this spring, I do not remember the exact date, Elizabeth would have been thirty years old. I was undertaking my JBCNS Course on Special and Intensive Care of the Newborn when I met Elizabeth who was born, out of the blue, at 26 weeks' gestation. This was on my first night duty of seven and so I was assigned her care under the supervision of a senior midwife, but as this was night duty, I was left more or less responsible. Over the next six nights, she struggled with all that prematurity could throw at her, she was not ventilated but given CPAP via a Gregory box – does that bring back memories? On the sixth night, I knew when I came on duty that she was now unlikely to survive and she died a few hours later.

Despite many previous experiences of death from working as a registered nurse, her death – as is probably demonstrated by the detail of this recall – touched me in a special way. Whether this was as a result of the intensity of the one to one care and concomitant responsibility or something about her amazing fight to survive, I do not know. On reflection, I realise I was considerably distressed by her death, which I expressed at the time by being angry that there was no shroud suitable for her tiny body, and so I cut one up and made it just for her – the alternative was an 'inco' pad. I think it was the contradiction, where so much appeared to have been done to save her life, but when this failed, it was replaced by disregard and disrespect for her and her life, however brief, that affected me more than anything. So, thirty years later, how have things improved for babies born too early, or too small?

I am very well aware of some very positive initiatives in neonatal care, both as a practitioner and then latterly from my access to publications as part of my job as editor of the MIDIRS, Midwifery Digest. However, when trying to establish whether there had been any actual epidemiological advances in this field, while I could not track down a rate for preterm birth for 1978, it does not seem to have really changed very dramatically with a recent figure being given of 6.2 percent[1] and one for ten years earlier being the same[2]. What has changed of course, is the chance of survival and overall improvement in neonatal outcomes and better information about these babies from collection of centrally held data[1].

A recent report that hit the headlines gives equivocal messages about the current state of the maternity services[3]. It is inevitable that any such report will be highlighted in the general press for the inadequacies demonstrated rather than the achievements, but what is perhaps most important is that there is now local information about local services. Where this framework is now in place, while the *accountability* is firmly with the service providers, the *responsibility* for change and improvement is possibly more with those within and outside of the health services to challenge the nature and provision of those services where they are lacking in meeting the needs of their population.

MIDIRS as an organisation has been pivotal in promoting the ethos of informed choice by providing access to information to maximise this, both for health care professionals and for women, and parents[4,5]. The most concerning aspect about the Health Care Commission report is the lack of choice for women and apparent lack of access to routine services, in particular antenatal and postnatal care. Where care is poor, this has negative effects on uptake of screening facilities, of choices for care provision and for changes in lifestyle that might affect the pregnancy outcomes.

So, if Elizabeth had been born this year, her chances of survival should have been different, but I am not sure what level of difference could have been made to the chances of her unexpectedly early arrival. We should not lose sight of the amazing advances, not only in medicine but in our social care and support of these babies and their families, that have taken place over this time. However, it is my view that the future lies not only in maintaining and improving, where possible, the care of the infant from birth, both within the setting of normality as well as in aspects of ill health, but also in trying to meet the demands of the challenges associated with neonatal morbidity where it arises from maternal causes whether these are medical or social[6]. The increasing multi-ethnicity of our population, concerns about poverty that relate to the resources needed to sustain health, in the form of nutrition and general lifestyle choices alongside inconsistencies in access to health provision are all factors to be considered if such a change is to occur.

As editor of the quarterly MIDIRS Midwifery Digest, I review hundreds of articles on a regular basis and this means that I can see a great deal of energy and effort being made to achieve better outcomes. While there are still gaps to be filled, some reflection on achievement for those working in these areas would not be unwelcome, I am sure!

Sally Marchant
PhD, RM, RN Dip Ed
Midwife and Editor of MIDIRS Midwifery Digest

References

1. **Moser K, Hilder L.** Assessing quality of NHS Numbers for Babies data and providing gestational age statistics. *Health Statistics Quarterly* 2008; **37**: 15-23.
2. **Department of Health** Statistical Bulletin 1997/28 9-10. 1997.
3. **Healthcare Commission 2008.** Key findings of the 2007 Maternity Services Review. www.healthcare commission.org.uk accessed 8/4/08.
4. **Carne V**. Facilitating informed choice for childbearing women and their families. *MIDIRS Essence*. 2007. Issue 11.
5. **Midwives Information and Resources Services**. Informed Choice Initiative www.infochoice.org 2008.
6. **Smith L K, Draper E S, Manktelow B N et al.** Socioeconomic inequalities in very preterm birth rates. *Arch Dis Child: Fetal Neonatal Ed* 2007; **92**: 1 F11-14.