Midwifery in the Netherlands

EDITOR,—We were amazed and also somewhat amused when we discovered that the Royal College of Obstetricians and Gynaecologists, in its response to the report of the House of Commons Health Committee on Maternity Services, did us the honour of citing our research on midwifery in the Netherlands, the Wormerveer study.¹ The royal college stated: “The [House of Commons] Committee’s thinking has been influenced by the Dutch system which directs women to midwifery care unless specific criteria indicate otherwise. The evidence from the Netherlands shows that if women are correctly categorised as low or high risk, the outcomes for both mother and child are favourable. However, if problems arise during pregnancy there is either insufficient flexibility or the interface between the two systems is inadequate to deal with them appropriately. The Wormerveer study reports a perinatal mortality in this group of 51.7 per 1000 which is clearly unacceptable.”² We would like to comment on this statement.

The perinatal mortality rate of 51.7 per 1000 is the figure in the subgroup (17.8% of the total population) referred to an obstetrician because of disease detected during pregnancy: hypertension, pre-eclampsia, fetal growth retardation, imminent preterm labour, etc. Perinatal mortality was much lower in the two other subgroups, referrals to the obstetrician during labour (7.9% of all women) and the group of women who gave birth under the sole care of a midwife (74.3% of women): 11.0 per 1000 and 1.3 per 1000 respectively. The perinatal mortality rate (stillbirths and neonatal deaths in infants ≥ 500 g) in the total number of 8055 infants was 11.1 per 1000, which during the time of the study (the 1970s and early ’80s) was relatively low.

Our comment on the critical statement of the royal college is: why is a high perinatal mortality rate in a subgroup of a population judged to be unacceptable if that subgroup has been selected deliberately because of an anticipated high risk, and if the other subgroups of the same population show a very low perinatal mortality? This distribution of mortality is evidence of a good selection system, rather than of inadequate care. The royal college apparently misunderstood the selection system leading to these results.

In our article¹ we did not mention that part of our study on avoidable factors related to the cases of perinatal mortality. It is described in the complete report of the Wormerveer study.¹ An independent committee investigated all cases of perinatal mortality and concluded that avoidable factors were present to some extent in a third of cases. This result is similar to the outcomes obtained in regional inquiries into perinatal deaths in Great Britain in about the same period.^{3,4}

We have the strong impression that the Royal College is condemning a system of obstetric care without sufficient information. The system of care

prevailing in the Netherlands deserves a more serious appraisal. An overview of the information available has been published elsewhere.⁵

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Disulfiram treatment linked with probation

EDITOR,—S K Rossiter’s lesson of the week about a man who developed psychosis while taking disulfiram prescribed under a probation order contains several important errors.¹ Under schedule 1A(6) of the Powers of Criminal Courts Act 1973 courts can make compliance with treatment by a named doctor, recognised under section 12 of the Mental Health Act 1983, one condition of a probation order. Courts do not automatically agree to any proposed treatment plan for the offender they are trying. For repeat offenders, many of whom misuse alcohol or heroin, they prefer plans that incorporate both systems that are effective at preventing and detecting relapse and the doctor’s agreement to report any important failures of compliance.

Even lawyers are fallible: judges sometimes specify disulfiram or naltrexone in probation orders, but the act gives them no power to do so. Treatment orders actually give the named doctor complete freedom to change the treatment plan if necessary, though important changes are usually discussed with the probation service. In the case reported by Rossiter, for example, calcium carbimide could have been substituted for disulfiram without the court’s permission being sought, but so could drug free treatment. Sobriety and avoidance of offending are the main criteria of success.

In 1984 the General Medical Council ruled that treatment with disulfiram linked with probation posed no ethical problems if the patient’s informed consent was obtained. Unlike offenders compulsorily treated under section 37 of the Mental Health Act, probationers can decline treatment and request a different sentence.

I have prescribed disulfiram for over 20 years, and Rossiter’s patient (originally mine) is the only person I have known to develop psychosis associated with the drug. Many schizophrenic offenders treated as a condition of probation receive neuroleptic drugs, which have a much higher incidence of side effects than disulfiram.

Supervised treatment with disulfiram is highly effective.^{2,3} Classic randomised controlled trials in recurrent alcoholic offenders have yet to be done, but a retrospective study found a 12-fold reduction in offending,⁴ and treatment with naltrexone linked with probation is effective in crime related to heroin.⁵ Many recurrent alcoholic offenders regard disulfiram’s occasional important side effects as an acceptable risk if it enables them to avoid further offences while preserving their liberty. The more important lessons are that disulfiram is a safe drug compared with the serious mortality of unchecked alcohol misuse and that treatment linked with probation can be a humane and adaptable alternative to prison.

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EDITOR,—We agree with S K Rossiter that it is wrong for courts to require specific drugs to be given as part of a probation order.¹ The prescription of any drug should always be a matter of clinical judgment and negotiated with the patient. A condition of a probation order may be that the offender follows treatment. If a treatment plan suggested by a doctor includes a drug, this will be prescribed and administered only with the offender’s consent. The fact that the offender has to agree “voluntarily” to the conditions of a probation order is not consent freely given when the alternative is custody or a fine.

We are concerned, however, that Rossiter chooses to make an example of disulfiram in this way. The prevalence of side effects and adverse reactions to this drug is low, and psychoses of the kind described are extremely rare at normal doses.^{2,3} It is surprising that Rossiter does not mention the dosage regimen. There are considerable benefits from disulfiram given under supervision at home in primary health care, in the workplace, or as part of probation supervision, but this must be associated with proper medical care.^{4,5} Criticism of the treatment seems misplaced when the flaws that the author observed were in the process of supervision. Social work agencies should not undertake matters of clinical judgment.

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Advice to authors

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