example, the observation log kept by nurses during surveillance reported that at 18.58 on 17 July 1992 "mum takes baby out of cot." Parents are always encouraged to be with and care for their children, but they are not expected to be the sole carer and thereby excluded from taking meals. It was evident from the log that this mother was frequently away from the observation cubicle. If she wishes her complaints to be investigated formally, she should use available procedures.

To date we have initiated covert video surveillance in 34 cases where suffocation or other life threatening abuse was suspected. Abuse was confirmed in 30 cases, and in one further instance a mother confessed to the murder of two previous siblings. In the remaining three cases the parents were aware, before admission for surveillance, that suspicions of suffocation existed. Two of these three patients were taken into care on other grounds and have suffered no further life threatening episodes.

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Dutch model of maternity care

Midwifery led service is safe

EDITOR,—We take issue with some of the points raised by Lawrence Mascarenhas and colleagues in their letter on the Dutch model of maternity care led by midwives.¹ Their claims are unsubstantiated, their citation of the literature is selective, and their interpretation of the statistics on maternal mortality is imprecise. They claim that women's choice is denied by midwives in the Netherlands. Their anecdote that "one of us is Dutch, and his sister had . . ." serves to emphasise that fact that they could not find any proper evidence to substantiate that claim.

They then mention the "unacceptably" high perinatal mortality among babies transferred to obstetricians by midwives in the Wormerveer study in the Netherlands, presumably to show that the Dutch system leads to a poor perinatal outcome. The high perinatal mortality of 51.7/1000 was in the subgroup (17.8% of all women) referred to an obstetrician antenatally because the midwife had detected a deviation from the norm, such as preeclampsia, intrauterine growth retardation, and threatened preterm labour. On the other hand, the perinatal mortality for those delivered under the sole care of a midwife (74.3% of women) was 2.3/1000 and for those referred to the obstetrician during labour (7.9% of women) 11/1000. The overall perinatal mortality was 11.1/1000.² Obviously, therefore, the high perinatal mortality in the first group of women reflected their obstetric risk factors. The overall distribution of mortality is evidence of a good selection system rather than of inadequate care.³

The authors also state that the maternal mortality is similar after elective caesarean section and vaginal delivery and cite the reports on confidential inquiries into maternal deaths as evidence. Such overall comparison of mortality is a misleading guide to the relative safety of different modes of delivery, as clearly shown by Lilford *et al.*³ Lilford *et al.* in the largest study of its kind in the literature, calculated the mortality attributable to vaginal delivery and to elective caesarean section after excluding indirect deaths and acute antenatal obstetric disturbances (which are not related to the mode of delivery). Elective caesarean section was associated with almost a fourfold increase in

maternal mortality over vaginal delivery (23/100 000 *v* 6/100 000).³

The available evidence suggests that a midwifery led system of care is associated with a good perinatal outcome and a low rate of obstetric intervention.

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- 2 Van Alten D, Eskes M, Treffers PE. Midwifery in the Netherlands. *BMJ* 1992;305:1155.
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Authors' reply

EDITOR,—Marion Hall's criticism¹ of our correspondence concerning caesarean section rates² is both incorrect and misleading: the 1982-4 confidential inquiry³ reports the rate of direct maternal deaths after elective caesarean section as 0.09/1000 (8/86 000)³ and the rate of direct maternal deaths after vaginal delivery can be calculated as: (total direct deaths-direct deaths after caesarean section)/(maternities-caesarean sections) = (138-44)/1 840 970-185 820 = 0.06/1000. A χ^2 test of significance shows that this difference is not significant ($\chi^2 = 1.265$; $P = 0.26$), which justifies our statement that maternal mortality after elective caesarean sections and vaginal delivery was similar. Hall was probably referring to the mortality after emergency caesarean section or caesarean section overall (0.36/1000) when she quoted a 4.5 times increased risk. After 1982-4, the inquiries could not provide the numbers of elective caesarean sections in England and Wales; hence the rates calculated by Hall for 1988-90 are at best an educated guess.³ In contrast we note that the overall mortality after caesarean section fell from 0.37/1000 in 1982-4 to 0.33/1000 in 1988-90.^{3,4}

Paula Clarke and colleagues mention the Lilford study. This relates to a South African population which may not be relevant to Britain and spans an epoch (1975-86) in which major obstetric changes occurred. In contrast, the confidential inquiries are the largest standing audit in the world, and direct deaths by definition exclude deaths not related to the mode of delivery. We were not suggesting elective section instead of vaginal delivery but merely questioning whether midwifery led care of women at low risk would result in more emergency deliveries with a corresponding bad outcome for mother and baby. Furthermore, both mortality and morbidity need to be taken into account, and others have begun to assess this.⁴

The Wormerveer study showed a perinatal mortality of 51.7/1000 for women referred antenatally, 11.0/1000 for women referred during labour, and 1.3/1000 (not 2.3 as given by Paula Clarke and colleagues) for those delivered at home. Our concern stems from the increased rate (10-fold) in the selected "low risk" women transferred in labour. We were not referring to the antenatal referrals, who would probably have had a poor outcome anyway. In the Leicester simulated home delivery in hospital randomised trial, 22% of transfers occurred during labour.⁵

We mentioned that "one of us is Dutch" to show that we are fully conversant with the Dutch system and to show that, in the debate between obstetricians and midwives about what is normal or not, it is the mothers who suffer.

Finally, the confidential inquiries have consistently called for the early involvement of consultants so that optimal care can be achieved.³ A team approach is therefore necessary. We can only repeat our warnings about a system that is not routinely audited, not cost effective, denies the women's choice of referral to an obstetrician in normal pregnancy,² and which may not suit Britain.

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Doctors and execution in Turkey

EDITOR,—I welcome the attention drawn by Paul Mansour to the likelihood of Turkish doctors being pressured into participating in executions.¹ The BMA has consistently supported the efforts of the Turkish Medical Association to resist this move. We also consider it a duty of sister medical associations like ourselves to take action when colleagues in other countries come under threat for resisting human rights violations.

Over recent years, the BMA has had cause to protest to the Turkish authorities on many occasions about the detention on political grounds of officials of the Turkish Medical Association and about the torture and murder of doctors who attempt to protect human rights in the Kurdish south east of the country. Regrettably, as Lord Avebury has reported,² this now means that doctors in that part of Turkey are increasingly reluctant to provide even basic medical treatment for Kurdish civilians for fear of reprisal. Turkish doctors are indeed caught between persecution and prosecution. I am glad to see recognition being given to the way in which the Turkish Medical Association is trying hard to maintain high ethical standards in the face of many obstacles imposed by the government. The Turkish Medical Association needs international support, and it is in this spirit that the BMA has taken a role.

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Patients' rights in Finland

EDITOR,—Tony Sheldon reports on a new Dutch law defining patients' rights and says that the Netherlands has become the first country in Europe to pass a law defining the responsibilities of doctors to their patients.¹ Finland has had a law on