The full range of maternity services should be available to all mothers. Ideally, therefore, general anaesthesia must be readily available and there should be facilities for the effective relief of pain in labour, including the provision of a service for extradural analgesia. However, there are often strong local political pressures to preserve small maternity units and even to establish new units in situations where factors which have an important bearing on the wellbeing of the women who may be delivered there are disregarded.

There are a few obstetric emergencies, including prolapse of the cord, antepartum haemorrhage and some cases of acute fetal distress in labour, in which immediate delivery of the child offers the only chance of its survival. Forceps delivery, breech delivery and the delivery of twins may require urgent anaesthesia and the quality of that anaesthesia will influence the condition of the infant. Arguably, all obstetric anaesthetics are emergencies, if only because the risk of vomiting or regurgitation is high, and the minimum acceptable level of clinical competence requires at least one year's experience by the anaesthetist. It is therefore becoming the practice to have an anaesthetist, often of registrar grade, permanently on call to deal with obstetric emergencies and perhaps to provide extradural analgesia. In very large obstetric units there is the potential problem of two or more emergencies arising simultaneously. The largest units in the United Kingdom rarely have more than 4000 deliveries in a year and seem to manage with one registrar on call, with back-up from a senior registrar or consultant for difficult cases or multiple emergencies.

In the small maternity unit there is segregation of an experienced registrar anaesthetist who, although providing an important service, is sometimes under-employed, even though the training and expertise of an anaesthetist allows him to give valuable assistance in cases of haemorrhage, eclampsia, amniotic fluid embolism and many other conditions. In small units also, the anaesthetist regularly undertakes the resuscitation of the newborn infant. Despite these activities the resident anaesthetist in a small maternity unit may sometimes feel that his skills are not adequately exercised and a sense of frustration and resentment can grow. Yet the fact remains that obstetric units can only have the safe and satisfactory anaesthetic services they require by the exclusive allocation to them of an appropriately trained member of the junior staff.

The small maternity unit presents another problem. A District or Area with 1000 or fewer live births per year is likely to be small in all dimensions. A junior anaesthetic staff of perhaps one registrar and two senior house officers is by no means unlikely. Under such circumstances the allocation of a junior to the maternity unit can be made only at the expense of failing to meet all the demands which are made by other specialties on the services of anaesthetists. The pattern of obstetric anaesthesia is changing. A growing number of women now receive lumbar extradural analgesia for the relief of pain in labour, for the delivery of twins and infants presenting by the breech, and as part of the management of pre-eclampsia and various medical conditions. The use of extradural and subarachnoid analgesia for Caesarean section is gaining favour. The result is that there is a much greater need for the presence of a consultant anaesthetist in the obstetric unit to teach techniques of regional analgesia to junior anaesthetists. In consequence an effective allocation of consultant sessions to the maternity unit is required also. Indeed, the Faculty of Anaesthetists insist on the designation of a named consultant in charge of the obstetric service as a condition of full recognition of a hospital or unit.

Overall it would seem that a unit with 2000 or more deliveries in a year can usefully and exclusively
employ a member of the junior anaesthetic staff throughout each 24 hours and will justify the continuous presence of the anaesthetist within the maternity unit. Even with the obstetric extradural service, however, units with less than 1000 live births in a year are uneconomic in terms of anaesthetic manpower and may well be uneconomic in terms of other personnel and facilities; yet the wellbeing, and even the survival, of mother or child may depend on the ready availability of a full range of all services, including the services of a competent anaesthetist.

It is hoped that Health Authorities will consider this problem very seriously and adopt as a policy progressive centralization of maternity services and, where possible, close units with substantially fewer than 2000 deliveries a year, especially when these are isolated and under-used. The case for closure of the small maternity unit is doubly strong when it is separated by some miles from the related district hospital. Indeed, if the small maternity unit in a district general hospital is undesirable, and perhaps even unsafe because it has been impossible and simply uneconomic to provide the full range of services, then the isolated small unit is even more unsatisfactory.

It is hoped that when new maternity units are being provided they will be of appropriate size and built within or alongside an appropriate general hospital. It is particularly desirable that political pressures for the opening of small maternity units and splitting of larger ones should be resisted.

A. R. Hunter
D. D. Moir

ERRATUM

PHARMACOKINETICS OF ALTHESIN

(Br. J. Anaesth., 50, 1232)

The fourth and sixth equations towards the bottom of the second column of this page should be amended, respectively, to:

\[ k_{12} = \alpha + \beta - k_{21} - k_{12} \]
\[ Vd_{ss} = \left[ \frac{(k_{12} + k_{21})}{k_{21}} \right] \cdot Vp \]