



BAPM News

Issue No 8

February 2004

From the President

At our last Annual General Meeting there was vigorous debate about the relevance of the word "perinatal" in the title of our association. There are dedicated fetal medicine specialists and obstetricians among our membership, and some have contributed to the work of the Executive Committee and continue to do so. However, their number is far outweighed by neonatologists and other professionals whose main interest is neonatal medicine. There was concern that BAPM wasn't doing enough to attract obstetricians.

Fetal medicine had not been established as a specialty when our Association was founded in 1976. Around that time the improving outcome for infants born at 28-34 weeks as a result of better neonatal care gave obstetricians a real choice in the management of compromised fetuses - either they remained in the womb or preterm delivery was initiated. In effect, neonatology was driving forward the need to develop new ways of assessing fetal health and maturity so that this choice could be put on a firmer footing. Fetal medicine has since grown rapidly with an increasing understanding of fetal physiology, and the introduction of a range of new diagnostic and monitoring techniques leading to a better appraisal of fetal health.

While continuity between fetal and neonatal life is central to perinatal medicine it is not the only interface that matters. The maternal-placental-fetal interdependence is exemplified by the new generation of specialists in foeto-maternal medicine.

Neonatologists have also dug their own furrows through an understandable focus on intensive care methods. Also, the importance of neurodevelopmental outcomes creates clinical pathways towards general paediatrics and paediatric neurology. It is inevitable that, as we learn more, the concept of perinatal medicine becomes more broad rather than being simply reflected in the partnership between obstetrician and neonatologist.

What has all this to do with the word "perinatal" in our association's title? We

must retain that word regardless of our membership bias towards neonatal medicine. We will always be a pioneering organisation because our purpose, which is "to improve the standard of perinatal care in the British Isles", will become more and more challenging as subspecialties around perinatal medicine continue to sprout.

Our membership continues to grow, and we welcome new members from all fields that impact on perinatal care. We will continue to exert our influence across a range of activities, including influencing government to ensure that service models reflect the interdependence of perinatal-related specialties; initiating work with other colleges and organisations on protocols and guidelines that require multi-disciplinary expertise; and, against the background of tensions and difficulties in implementing clinical research, and the changing scene in the NHS for junior doctors in training we will review our role in research, training and education.

Finally, I am pleased to announce that Professor Philip Steer [Academic Head, Obstetrics and Gynaecology, Chelsea and Westminster Hospital] and Dr Sandie Bohin [Consultant Neonatologist, Leicester Royal Infirmary] have agreed to lead on a new BAPM project to develop a national reporting system of emerging risks in perinatal medicine.



Clinical Excellence

The purpose of this newly constituted committee is to develop documentation and procedures to underpin excellence in perinatal care in the UK. What this means in plain language includes devising a critical incident reporting system which will (a) be useful to the clinicians submitting the information and (b) inform BAPM of the main underlying causes of adverse events in perinatal care. To this end, Sandie Bohin (Leicester) and Phil Steer (London) have enlisted the assistance of Capsticks, a leading firm of medical litigation solicitors, in setting up a website for critical incident reporting.

The idea is that clinicians 'at the sharp end' can, via the internet, enter a secure site under the auspices of BAPM (but hosted by Capsticks) and register details of critical clinical incidents into a structured database. These reports will then be assessed by a multidisciplinary committee (including obstetricians, neonatologists, nurses and midwives) and classified according to scheme currently under development. Subsequently, the database can be analysed using 'root cause analysis' that breaks down putative causes into categories such as 'risk identification',

LEARN MORE ABOUT THE LANGUAGE OF NEONATES

AT THE FIRST CLINICAL CONFERENCE OF ITS KIND

"Enriching Early Parent-Infant Relationships"

WITH DR. T. BERRY BRAZELTON AND DR. KEVIN NUGENT,
AUTHORS OF THE NEONATAL BEHAVIORAL ASSESSMENT SCALE

This is an exciting opportunity to hear Dr. Brazelton, and a wide range of other eminent specialists, give clinical and research presentations on infant behaviour and early parent-infant relationships. The conference is aimed at all health professionals working in this area.

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All attendees must be preregistered. For further information and to request a registration booking form, please contact:

Brazelton Conference Secretariat
c/o Meeting Makers Ltd.
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Tel: 00-44 (0) 141-434-1500
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Email: brazelton@meetingmakers.co.uk

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DATE
THURSDAY
4TH MARCH
2004
FRIDAY
5TH MARCH
2004

LOCATION
CHURCH HOUSE
WESTMINSTER, LONDON
CONFERENCE FEE: £125.00 WITH PREREGISTRATION

 **the Brazelton Centre**
IN GREAT BRITAIN
Understanding Newborn Behaviour

 **Johnson & Johnson pediatric institute**
Shaping the future of children's health

British Association of
Perinatal Medicine
(BAPM)
and
British Paediatric
Allergy, Immunity and
Infection Group (BPAIIG)

JOINT MEETING

31 March 2004

RCPCH Spring Meeting
York

9.00am-12.30pm

cont. from front page - Clinical Excellence by Phil Steer

'team factors' and 'resource factors'. The assessment of each report will be fed back to the reporting clinician.

Once the database starts to accumulate, reports can be generated as to the major causes of critical incidents. Contributors will be told how many other reports similar to their own are on file, and will have access to these anonymised reports. This will assist them in deciding whether their problem was a 'one off' or symptomatic of a more general failing. In due course, BAPM will be able to use the database to recommend areas for clinical development and investment in education and preventive strategies. Ultimately, the concept is that reporting a particular incident will automatically trigger suggested interventions to prevent recurrence, including directing contributors to appropriate evidence bases and guidelines.

The subcommittee will include ten members (Sandie and Phil included). If you are interested in joining this group, please contact David Field at BAPM. If you would like to discuss this further before committing yourself, feel free to contact Sandie on sandy.bohin@uhl-tr.nhs.uk or Phil on p.steer@imperial.ac.uk.

Phil Steer

ANNUAL SCIENTIFIC MEETING 3 September 2004

Call for Abstracts Deadline: 5pm on 4 June 2004

Abstracts are invited for oral presentation at the annual scientific meeting on 3 September 2004 in Manchester. Abstracts should be submitted online (www.bapm.org) or using the form available from the website or the Administrator. For more information, see the website or the leaflet contained in this newsletter.

David Harvey

October 2002 marked the retirement of Professor David Harvey, Honorary Archivist to BAPM. David was appointed a consultant in 1970 at Queen Charlotte's and Chelsea Hospital in West London and at the time of his retirement was Professor of Paediatrics and Neonatal Medicine, Imperial College London. However, his contribution to the care of children and babies extended far beyond his own institution. David worked with many professional and government organisations in the UK and abroad in the course of an extremely distinguished medical and academic career, but it is as a champion for the disadvantaged and as an advocate for mothers and children that he made a very personal impact. His career spanned a period of enormous change, particularly in neonatal medicine. In what was a conservative academic

climate, he did not hold back from supporting research into therapies complementary to conventional medicine. He was among the first to support the development of breast milk banks and to insist that there should be hospital residential facilities for mothers whose babies were in intensive care. He worked tirelessly, in both official and personal capacities, on behalf of children with AIDS, victims of child abuse, children in hospital, overseas doctors, and gay and lesbian doctors. His door was always open, and many a colleague, junior and senior, will remember his wise counsel during



troubled times. In 1999 he was awarded the James Spence Medal by the Royal College of Paediatrics & Child Health for "outstanding contributions to the advancement of paediatric knowledge". He stood down as Head of Paediatrics at Hammersmith and Queen Charlotte's Hospitals in 1998 because of ill health. The festschrift held at the Hammersmith Hospital on his retirement was a testament to the warmth, affection and esteem in which he is held by parents, patients and colleagues. David sparkled with a love of his profession and of life. His parties in the house he shares with his partner of many years, Teck Ong, have always been memorable – David, resplendent in bow tie and braces, champagne flowing and Teck capturing us all in his drawings. We wish them both well.

Neena Modi

Letter from the Honorary Secretary

Some of you will have noticed that, as promised in the last newsletter, we have established an area of the BAPM website to collate information about the various neonatal networks as and when they become established. At the moment I have just given some preliminary information about my own local network as an example of the sort of information we would like to collect. I want to try and encourage as many of you as possible to send in details about what is happening with regard to the development of a neonatal network in your area. I think this will be very important if we are to get any real feel for the extent to which the new national plan for neonatology is being implemented across England (the only part of the UK affected at present). I do know that the rate of change shows great variation from area to area. Similarly there is a great deal of variation about how different networks plan to interpret the recommendations of the national plan. Perhaps more important it seems that a lot of this year's targeted recurrent funds will not be able to be spent strategically to support neonatal care as the money arrived with Commissioners too late. (The money actually went to PCTs who should have been passed it on to the relevant specialist commissioners in each locality. The efficiency and reliability of funds reaching the right hands across England via this route also, anecdotally, seems very variable.) I also want to stress the importance of watching how obstetric services are affected by the introduction of neonatal networks as the implications are going, inevitably, to be on the perinatal service. In the longer term we may be able to acquire this type of information by a regular e-mail dialogue with the

relevant lead clinicians but until all of those are in place we will need to rely on local members. I want to stress that as we acquire and collate these data we will make sure it is available to all members. We are keen to hear from anyone (not just medical members) about these developments.

Many thanks to all of those members (about 90) who responded to our request at the end of last year for information about on going problems in relation to nurse practitioner prescribing. I have placed the relevant correspondence about this on the web site. It seems that there are mechanisms in place to allow nurse practitioners to "prescribe" for predictable situations although the remedies are not very user friendly and in general involve extra training that has only passing relevance to neonatal care. For the unpredictable situation it would appear that the legal position can, at best, be described as ambiguous. This is, of course, also a problem for many specialties outside neonatal care and DoH recognise that potentially problems over nurse prescribing could jeopardise existing plans for "modernising working practices" within the NHS. In response to the current problems the DoH are planning a new Bill and we are currently in the phase where we can comment on what is proposed. I would encourage those of you that have invested much time on this problem to look at what is proposed (see the website) and let us know very quickly if you feel that it will not resolve the current problems. We can then construct an appropriate BAPM response.

I just want to finish with a word about some of the meetings planned for later this year. The Trials Group meeting will



take place on 19 May 2004. In recent years the various programmes arranged for this annual meeting have been excellent but attendance very poor. At present we run these meetings at a loss. Perhaps such meetings are no longer felt relevant? If you disagree please look at the programme for this year's meeting on the website and try to attend. Our next trainees day is planned for 10/11/04. The previous two events have proved very popular but have had a heavy neonatal bias, in terms of the audience. In order to try and deal with this we tried to make this next meeting a joint effort with BMFMS. In collaboration with the officers of BMFMS we drew up, in my view, an excellent perinatal programme. However the executive of BMFMS later decided that they would not support the venture. Therefore the day will go ahead under BAPM's name alone but we have decided to continue with the programme as originally devised. We hope that as many of you as possible will encourage trainees from obstetrics and neonatology to attend. Other members (eg ANNPs) will also be very welcome. And finally I hope to see many of you in York. Please remember that as well as the usual perinatal session on the Tuesday there is a joint meeting with the Infection, Immunity and Allergy Group on the Wednesday as well as plenary presentations with a perinatal theme across the week.

Appeal for useable equipment etc for Uganda

I have recently returned from Uganda and found quite a lot of interesting developments. One of them particularly caught my eye. It is the brainchild of some young Cambridge graduates (most non-medical) who came up with the idea of setting up an International Medical School to provide experience in Tropical Medicine to the West while at the same time training local students. It is still in its

infancy but has already attracted some funding from NGOs in the USA and Germany. They are, however, desperate for equipment and I am trying to help them by sending condemned but usable, sterilising units, ventilators, incubators, infusion pumps, monitors etc. They will probably finance shipping. They may not, however, be able to accept everything. If you have any items which you think may

be suitable, please contact me on jasper.katumba@mkgeneral.nhs.uk. (Dr Jim Appleyard, a retired paediatrician and current president of the World Medical Association is particularly interested and I am sure he will not mind me saying that he will be happy to address groups that are interested.)

*Jasper Katumba
Milton Keynes*

Memories of Bangladesh

In 2001, I was in the north of Bangladesh working for an international aid charity called Concern, visiting one of its health programmes which had been set up to achieve a significant reduction in infant mortality in two neighbouring cities called Saidpur and Parbatipur. One of our teams had been using focus groups of young married women to find out why the area had such a high incidence of low birth weight babies and they had

discovered something quite shocking. Some of the women had described how they would force themselves to eat less during pregnancy. They explained that there were few hospitals and that they could not afford

to use them anyway. They delivered their babies at home, and would do this either without any help at all or with the assistance of a traditional birth attendant: a respected local woman who had no medical training. The women knew that giving birth was highly dangerous for both mother and baby, especially if the baby got stuck half way through the delivery. They had concluded that small babies would most likely come out easier and so the practice of half starving themselves for several months before the due date had become a respected coping strategy for many poor women in the two towns.

The results were devastating for both mother and child but the logic of their decision could not be faulted when we consider the lack of health information available to the mothers, and their lack of choice regarding their healthcare. With very little money and low social status the amount of food they consumed was one of the few things the women could exercise some control over. And so they took action to protect themselves and their babies.

I carried this memory with me when I joined BLISS and I refer back to it with two main thoughts. This first is that mothers, and most often fathers as well, will do anything they can to protect their children. This basic human motivation is a force for good and needs to be supported at every term. The second is that any organisation like BLISS which sets out to help others will be faced with the dilemma of whether to spend all its

money on bringing urgent help to a few people, or to work for longer term change which can potentially benefit huge numbers. The babies of Bangladesh won't really be safe until that country surmounts enormous social

and economic problems. In the meantime in Parbatipur and Saidpur we created a network of mothers who we trained to pass on the right health advice to their neighbours. We also trained a large number of traditional birth attendants in basic skills and enlisted them as ante-natal advisers to their communities.

The challenge for BLISS is to continue working towards the transformation in the way that neonatal care is organised and campaigning for it to be adequately funded throughout the United Kingdom whilst providing practical interim support to health professionals and parents. We believe that the BAPM 2001 guidelines for neonatal care have a practical and ethical force which we support and hope to see realised in the not too distant future. In the meantime, we do whatever we can to mitigate the problems of the here and now.

*Rob Williams,
Chief Executive of BLISS*



From right to left : Malcolm Chiswick (BAPM President), Kate Costeloe (BAPM EC), Bonnie Green (BLISS) and Rob Williams (BLISS)

Diary Dates 2004

29 Mar-1 Apr

RCPCH Spring Meeting, York
(Main perinatal session: Tuesday;
Joint meeting with BPAIG:
Wednesday 0900-12.30)

1-2 Apr

BMFMS Annual Meeting, Glasgow

19 May

Clinical Trials Group meeting
at RIBA, 66 Portland Place, London

7-9 July

British Congress of Obs & Gynae
Glasgow

2-3 September 2003

AGM and Scientific Meeting
University of Manchester, Hulme Hall,
Manchester

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www.bapm.org

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Perinatal Clinical Trials Meeting

19 May 2004

RIBA, 66 Portland Place, London W1

see enclosed leaflet or register online at www.bapm.org