(Russell)

BIRTH: WHO DELIVERS BEST?

Your third birth article "An unexpected life" (March 26) exposes some troubling problems about obstetric ultrasound in New Zealand. As a practising sonographer, I extend my sympathy to the Gallaghers who nearly lost their baby, partially due to errors involving ultrasound.

The problem is not with the technology but with the people who use the machines. If the skill and knowledge are missing, the results can be wrong, sometimes dangerously.

Two groups of people are involved in ultrasound scanning — sonographers and doctors. The sonographers are drawn almost exclusively from the ranks of radiographers, while the doctors include a variety of specialists and some GPs.

The sonographers and all non-doctors are required by law to be registered by the Medical Radiation Technologists' Board (MRTB) in order to use ultrasound equipment on humans. To achieve registration they must have the Diploma of Medical Ultrasonography (DMU), which is awarded after the sonographer has passed a two-part examination including 12 hours of written examinations and separate practical and oral examinations, as well as two fulltime years of approved practical work.

Doctors are exempt from the requirement to be registered. They are free to use ultrasound equipment whether or not they have training or qualification. There exist two sources of qualification in ultrasound for doctors. The first is the inclusion of ultrasound in the training of radiologists in the years since ultrasound came into existence. Some radiologists build on this training and become ultrasound experts. The other qualification is the Diploma of Diagnostic Ultrasound (DDU) offered by the same body that examines for the DMU. This is the true specialist ultrasound qualification for doctors. A few radiologists hold this qualification in New Zealand.

Most, but not all, sonographers comply with the law, the majority being qualified and registered. The ones who are not have little to fear, however, since the MRTB has never brought action against anyone. Nevertheless, the regulations, peer pressure and the public hospital system have encouraged the formation of a substantial group of well-trained professionals.

Unfortunately, the trend among doctors has been in the opposite direction, much to the consternation of responsible doctors. It is possible for any doctor to buy a cheap machine of limited performance, or a used, obsolete machine, and begin charging fees from both patients and the Government, as Dr Dermot Mora points out in the article. There is an incentive for profiteering. It is in the private sector that this happens, beyond the reach of peer pressure or public scrutiny.

What can be done about the "cowboy element" in ultrasound?

First, the public can ask questions of both the referring doctor and the person doing the scan:

- What qualifications and experience does the operator have?
- How modern and sophisticated is the equipment? (Most machines more than five years old are obsolete.)
- May I see the ultrasound image and will it be explained to me?

Second, the Health Department can take steps against bad ultrasound practice in several ways:

- By not paying unqualified doctors.
- By assisting the MRTB to enforce existing regulations regarding sonographers.
- By bringing in mandatory licensing of all doctors using ultrasound.
- By funding training programmes in ultrasound.

Ultrasound has transformed modern obstetrics. It is an essential tool that is safe and reliable in competent hands. Unfortunately, a profiteering element is betraying the patient's trust and bringing ultrasound into disrepute.

Martin Rothman
(Wanganui)

I enjoyed your series on aspects of childbirth. However it left me with a major concern — that is, when a patient complication occurs in a private hospital it often becomes the public sector's problem and expense.

Miriam Gallagher was given a scan in the private sector. When the scan was interpreted as showing the baby was dead, her GP referred her to the public hospital for an induction.

When Cameron was induced, 14 weeks premature and alive, it became the public system's fault — and expense. If your costing of $1000-$1200 a day is correct, then the public health system had to pay in excess of $106,000 to rectify the private health "service" error.

I am delighted that the excellence of medicine saved this little boy's life. They were making up for their colleagues' errors. I do wonder if the time has come for the public system to charge the doctors at fault for this sort of referral.

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