of the resources that physical and natural sciences make available to us. At the same time there is no reason why research in indigenous medicine should not be stimulated so as to secure from those systems all that is scientifically proved to be valuable to mankind, whether it be in the realm of drugs, principles, or special practices. Thus it may well be that modern medicine will in due course emerge enriched by all that is demonstrably good in our ancient systems.

I would also add that India's active participation in the work of the World Health Organization is further evidence of her interest in modern medicine and of her desire to utilize it fully for the good of the people. If she was really opposed to the practice of modern medicine she would not have pressed for the location of the headquarters of one of the Regional Bureaux of WHO in India. Indian medical scientists are serving on the expert committees of that organization dealing with cholera, plague, trachoma, venereal diseases, malaria, tuberculosis, and maternal and child health. India has undertaken to carry out extensive investigations into various problems relating to cholera at the request of the Expert Committee on Cholera, and that committee is being invited to hold its next meeting in India towards the end of the year.

As has already been pointed out, a large-scale programme of B.C.G. vaccination is in progress with the assistance of the World Health Organization and the United Nations Children's Emergency Fund, and these two organizations as well as the Food and Agriculture Organization are helping India with teams of experts and equipment for starting centres of active work on modern lines in respect of malaria, tuberculosis, venereal diseases, and maternal and child health. Lastly, I may mention that during the past three years a scholarship scheme sponsored by the Government of India has sent abroad to the United Kingdom and the United States a few hundred medical men and women for postgraduate training in various subjects.

It is pertinent to quote here the remarks on indigenous systems of medicine which the Hon. Rajkumari Amrit Kaur, Health Minister with the Government of India, made in the Dominion Parliament in 1948 during the debate on the health budget:

"I do want members to realize that there can be no question of the indigenous systems supplanting the modern scientific system. Science, as I have said once before, knows no barriers of race or clime. Knowledge gained through research and practical application may not be ignored. It would be folly for us to dwell on or rest content with our achievements in the past and shut the windows of our understanding, as it were, to the light of modern scientific achievements in the vast field of medicine and surgery. I am sure it would be wrong on the part of any State not to try to afford the best and most scientific medical relief to the sick and suffering committed to its charge. It does not follow that the cheapest is the best. If we have not been able to afford adequate medical attention and relief so far, that is surely both our fault and our misfortune. It is not the fault of any system. Scientific knowledge of chemistry, of physics and biology, of the structure and functions of the various tissues and organs of the body, sufficient knowledge of surgery, of sepsis and a sepsis, of bacteriology, x rays, electrotherapy, dentistry, and modern public health—these are the minimum essentials for anyone who can claim to attend to sick and suffering humanity. The important thing for us to consider is in what condition the indigenous systems of medicine to-day are and what is necessary to make them a progressive scientific art. We may not, we dare not, be content with less. There is ample room for research. Whatever in either the Ayurvedic or Unani systems of medicine or in homoeopathy stands the test of scientific scrutiny must and will be translated and synthesized in modern scientific medicine and added to the

fund of world knowledge, and I would beg of the House to agree with me that it is in the spirit of the quest for truth—and what is science but a quest for truth?—that we must go forward and see to what extent indigenous systems can be developed and regulated for medical relief in the country, and not in any spirit of rivalry with allopathy."

The Prime Minister of India holds equally strong views regarding promotion of the scientific approach towards the study of health problems and their solution. In the circumstances it seems to me quite unlikely that India will turn her back on scientific medicine and follow for sentimental or even mystical reasons any other form of medical practice.

MATERNITY AND THE NATIONAL HEALTH SERVICE*

BY

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The maternity service, unlike all the other medical services save only those dealing with child welfare, is in a very special sense concerned with health. In any area its function is the promotion and the maintenance of the health of a group of individuals for the most part in the prime of life and whose numbers, and therefore whose needs, can be estimated with considerable accuracy. A maternity service succeeds in the measure in which it exercises a continuing and enlightened care of the woman and child throughout pregnancy, labour, and the lying-in period. It is bound to fail in proportion as it permits this care to be broken at any stage or when it allows it to pass into the wrong hands.

At a time when we were on the average losing between four and five out of every 1,000 pregnant or parturient women there were throughout the country many examples of large maternity practices which showed year after year a death rate of 1 per 1,000 or less. It is well known that such practices were always those in which the administration was based upon a unity of control and direction of the various component elements of the service—midwife, clinic, health visitor, doctor, consultant, and hospital. It was apparent to all who gave thought to the matter that the high national mortality rates persisted, despite the experience of these scattered areas in which local enterprise was saving mothers and babies, because of the low standards which continued to prevail throughout the country generally. It is important to note that the low mortality and morbidity rates of mother and child characterizing these efficient practices were being obtained before the advent of sulphonamides brought down in a remarkable way the loss of life from puerperal sepsis and from 1936 onwards led to the first real downward trend in the total maternal death rate. This saving of life was in no sense due to an improvement in the standards of midwifery. There was as much puerperal infection due to the same cause as before, but this infection and these causes were concealed by the life-saving properties of the new drugs.

It was also notorious that these high annual death rates persisted despite the great improvements which occurred in the training of midwives and doctors, the increasing attendance of women at the antenatal clinics, and the rapid

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increase in the number of hospital beds. The State, local authorities, and the schools were at high cost improving and increasing the facilities available for maternity, but they were failing to make any impression on the national mortality figures.

Unity of Control

The successful and pioneer services which, as we have seen, were springing up throughout the country achieved their success by placing midwife, doctor, specialist, and hospital under one control. In some cases, as in Croydon, this control was centred in the local health authority and the medical officer of health. In other cases, as in some hospitals attached to teaching schools—e.g., Guy's Hospital—the control was vested in the teaching hospital. The main thing that mattered was not so much the source of the control as the fact that it existed as an intimate, living, and actively vigilant entity. The main characters of all such ideal services were easy to recognize. One of the dominating features was the corps spirit which pervaded the team. With the unity of control there was associated a unity of purpose. Midwives, doctors, and consultants had each a sound knowledge of the part they had to play in the team, and they were secure in this knowledge.

The antenatal clinic, which in a sense formed the pivot of the service, was a common concern of all. Here the cases were studied with care, and in this function all members of the team shared. The normal healthy women—the great bulk of the total—fell naturally to the lot of the midwife for their delivery. The emphasis throughout was on health, and the dominant role of the midwife meant that labour was allowed to express itself as an entirely physiological act, and the disasters attendant on premature attempts at delivery and “failed forceps” were eliminated. At the same time at the clinic the small proportion of women whose pregnancies departed from the normal were immediately brought under expert care and in the vast majority were steered safely through to the end. For them, if necessary, the admission to hospital was an easy arrangement made immediately between two members of the one team. There were no administrative gaps often spelling an inevitable break in the continuity of the care and the tragic loss of valuable time and a rapid tilting of the scales against the patient. The preventable deaths that constitute the great bulk of the maternal death rate and that appear in the mortality statistics under such headings as sepsis, puerperal shock, haemorrhage, etc., were virtually expunged from such a service. Its success was signalized by the delivery of two, three, four, or even five thousand consecutive cases without a death.

An important advantage of such a unitary control is that it makes possible an efficient system for the recording of the clinical notes and the statistical results throughout the service. This is indeed an essential element in the continuity of supervision from the time the woman is enrolled until she and her infant are discharged, and it is equally essential for the accurate compiling of the statistical records, by means of which results are scrutinized and improvements devised. It is notorious that where records have to be passed backwards and forwards between different authorities not only is there delay that may be dangerous but there is apt to be a lack of uniformity in the standard of the recording.

A further advantage of the close co-ordination of the various aspects of the service—domiciliary midwifery, the clinic, and the hospital—is that it creates the only sound structure for the training of midwife and doctor in the fundamental principles that must inform all good maternity practice.

The various plans that from time to time have been put forward for a National Maternity Service have without exception been based on these principles. They formed the main recommendation in the Report on a National Maternity Service promulgated by the Royal College of Obstetricians and Gynaecologists in 1944. These plans have for their support evidence derived from well-attested experience throughout the country extending over several decades, and they are put forward with powerful backing.

Effect of the New Service

Instead of a system which makes for co-ordination of effort between the various agencies concerned with maternity the new Health Service dissipates the control of this supreme single process over three different authorities, all heavily burdened with multiple administrative problems and in all of whom claims of maternity must necessarily constitute merely one of many commitments. The midwife and clinic fall under the control of the local health authority (the county or county borough council); the general practitioner, who is invested with new statutory functions in relation to midwifery, is under the executive council; whilst the specialist and hospital are controlled by the regional hospital board, or the board of governors in the case of a teaching hospital.

Here we have, indeed, the very antithesis of that intimate and living collaboration which animates the ideal service for which so many of us have been working during long years. Instead we are face to face with a distribution of responsibility so grotesque that many women will necessarily during the nine months of their child-bearing come under three different agencies. If she has a general practitioner as well as a midwife, and if finally she is sent to hospital, she may find herself enrolled, it may be within a few days or even a few hours, on the records of three different administrative authorities.

Those of us who have experience of large administrative bodies which transact their business at monthly meetings and whose officers cannot be expected to make rapid decisions on questions affecting policy will realize the gravity of the situation with which the new national maternity service is faced. It is peculiarly unfortunate that unless some adjustments are accepted the new provisions will virtually block the free expansion or even the existence of those pioneer efforts which had so signally established the value of unitary control. To many it must seem as if a black cloud had descended upon a vista that seemed to be full of promise for the future of our science and art.

Doctor and Midwife

The new provisions have been criticized on other grounds. Among these is the risk that the terms under which the general practitioner is included in the service may seriously prejudice the status of the midwife. In this connexion it is important to note that with her improved training and status the midwife has with advantage to the service gradually assumed more and more the responsibility for the care of the normal case. In 1946, as was shown in *Maternity in Great Britain* (1948), the midwife was responsible for 72% of all deliveries, including domiciliary and hospital cases. The new provisions are associated with the risk that she may be displaced by the general practitioner from the position which she has rightly won for herself. This would seriously imperil the security of the whole service, for it has long been recognized that for normal delivery the general practitioner with his many other commitments is less suited. At the same time, to give him a statutory position which

leaves to him the decision whether he should or should not be present at the delivery may easily be transformed into a position in which the patient would expect or even demand his presence.

Even now, despite the strong claims which the midwife has established for herself, there are still many women who in a free service would choose a doctor because he can bring her relief for her pains, which many midwives are still unable to do, and because of a fancied greater security. If this attitude were to become general it would at once degrade the midwife to the status of the maternity nurse and rob her of the independence in her own sphere which she rightly cherishes.

Clinic Officer

It is known that this unfortunate trend has taken place in some areas, and the Ministry in a pamphlet, E.C.N. 27 (July, 1949), has voiced its concern. In this pamphlet it is stated that the reason for the inclusion of the general practitioner is because hitherto "the medical officer in charge of the clinic could accept no responsibility if an abnormality arose, and the midwife had therefore to call in a general practitioner who had not previously seen the patient." It is true that this was one of the serious defects in the former maternity services. It was a defect which arose out of a division of responsibility, and it is unfortunate that in an effort to solve it the Ministry has adopted a policy which still further complicates the allocation of responsibility. It would surely be a simpler and more effective arrangement to remove the embargo at present placed on the clinic officer. In the midwife's case he has already been concerned with the antenatal supervision of the patient and, apart from this embargo, for which there was formerly some sanction but which should no longer be operative, he should in accordance with the plea put forward in the Ministry's own circular be a more proper person to deal with the midwife's emergency than the general practitioner whom it is now proposed to bring on to the stage to enact a part for which he may or may not be fitted.

It is true that many clinic officers are no more expert in practical obstetrics than many general practitioners, but the new service recognizes this and is taking steps to rectify it. It is equally true that some time will be required for the evolution of the clinic services in this respect. But it may be argued that it would be in the better interests of the service to encourage such a development, with the knowledge that meanwhile the clinic officer in time of difficulty has access to the specialist and the hospital. We have already seen that in many well-organized services the specialist staff of the hospital officiate at the clinic, in this way forging the links between midwife, clinic, and hospital.

Place for the General Practitioner

That the general practitioner should be constrained to enter normal midwifery for the purpose of securing for the patient the benefits of analgesia and anaesthesia brings with it, as I elsewhere hinted, quite definite risks to mother and child. For the busy practitioner, if he pledges himself to be present at the labour, must often find that his conscience demands the breaking of this pledge if he is not to be compelled against his better judgment to interfere with the course of normal labour. In the one case he forfeits the confidence of his patient; in the other he embarks on a course that leads often to disaster. For these reasons it has rightly been argued that the best solution of an admittedly difficult problem is to train the midwife in the use of safe analgesics, such as gas and air, and by

the prosecution of research to obtain better and more easily handled analgesic preparations.

In making these observations directed to the unification of the various branches of the service I do not wish to imply that there is no place for the general practitioner in obstetrics. Many practitioners are expert in this class of work, and in group practices these general-practitioner obstetricians can show good records. There would be a great advantage in encouraging such doctors to serve on the clinic and be available for emergency calls. In rural districts they give valuable service in the smaller maternity hospitals. Further, the family doctor by his special knowledge of the patient and the confidence which he inspires may be called upon to play an important part in the supervision of the general health of the mother and in the subsequent care of the child.

The risk that the provisions of the new service may lead to a competition between the doctor and the midwife for the care of normal midwifery is, as we have thus seen, a very real one. It is a risk that can be satisfactorily allayed only from the centre. It will gravely endanger the status of the midwife and the doctor alike, and it demands urgent readjustment to prevent grave dislocation of the peripheral services.

Reintegration of Purpose and Effort

It is a matter for serious thought how far we can devise, within a system that has succeeded in driving such deep wedges between the different agencies dealing with maternity, an adequate means of achieving a reintegration of purpose and effort. Already there have appeared various proposals to this end. Thus the Report of the Working Party on Midwives (1948) recommends that "in each hospital region a maternity services committee be set up to include obstetricians, general practitioners, and midwives" (para. 104). An informed article in the *Practitioner* (1949) suggests that each regional board "should be made responsible for co-ordinating the maternity service within its region." An objection which may justly be advanced against proposals based upon such regional action is that the regional board is neither by its representation nor by its function well equipped to initiate such a step. The concern of the board is the provision, maintenance, distribution, and integration of the hospitals over an area which is necessarily large and may indeed include several counties and many local health authorities. Thus in England, Wales, and Scotland there are well over 400 local authorities responsible for maternity and child welfare, whereas there are only 19 regional hospital boards. These boards, it is true, have under their jurisdiction the maternity hospitals in their areas, except those under the boards of governors of teaching hospitals. But their statutory concern with midwifery is solely in relation to the hospital and the specialist staff in their areas and to the provision for the local authority of beds and care for the large number of normal and the smaller number of abnormal cases that require admission to hospital.

It is primarily the extent of the local authority area and the needs of its obstetric community that must determine the size and distribution of the local maternity hospital or hospitals and the nature and extent of the services to be rendered by them. In regional board areas there will on the average be over twenty such local authorities requiring services varying from area to area in extent and in kind. It is, moreover, in a very special measure the local authority that, through the work of its midwives, its medical staff, its health visitors and clinics, sets the standards of service obtaining in the area not only for the domiciliary but also

for the hospital service. It is the local authority, moreover, that exerts a major influence in the disposal of the patients in relation both to home and to hospital delivery.

A further cogent argument against placing the onus of co-ordinating the maternity services on the regional board is that in each regional area the responsibility for the provision of the required facilities is shared to a considerable extent by the board of governors of the teaching hospitals. Furthermore, as we shall see, the functions of the two boards in the sphere of maternal (and child) health in a fully developed scheme are in some respects quite different.

For all these reasons it is difficult to envisage the regional hospital board as the agent which should appropriately be expected to assume the administration of the maternity in their area. At the same time it is obvious that, through their control of the hospital and the specialist staff, and such essential ancillary services as blood transfusion, the emergency "flying squad," etc., the regional boards must exercise an important influence on the structure and practice of midwifery within their territory.

How to Get Unification

I have previously indicated that the ministerial decision to disperse the administrative control over three separate agencies has resulted in a situation which is even more confusing than that existing before the Act. It has tended to consolidate by statute a system which, though unsatisfactory, yet had some fluidity and allowed of the creation by local enterprise of many efficient peripheral services. It must be our object to discover how far, in the absence of any central policy directed to the encouragement of collaboration between the disparate elements, we may yet be able to secure such a measure of unification as to prevent the major risks.

We have at the outset to emphasize that unification is meaningless except in so far as it achieves at the periphery a close and active collaboration between all the elements concerned. The building up of an effective national service means a system in which all of the multitude of separate services throughout the country are each capable of creating from their own resources, both human and material, a cohesive and self-sufficient unity. In this is to be found the sole guarantee of safe midwifery. Central direction and guidance could have made this end more easy of attainment, but even if this direction and guidance are denied us we dare not relinquish the effort.

The aim, then, must be to devise some method by which domiciliary midwifery (local authority), hospital (regional board or board of governors), and doctor (executive council) can combine in their areas to close the administrative gaps that threaten the safety of their mothers and babies. In a previous communication (Young, 1943) I have discussed this problem in relation to the organization of the maternity and child-welfare services for the efficient teaching of medical students, doctors, and midwives. Though on that occasion the problem was reviewed from an angle somewhat different from that with which we are now concerned, the argument then advanced applies with equal force to our present need. I then suggested that the linking of the department of obstetrics of the medical school and hospital with the local welfare authority would provide the intimate collaboration between the hospital and specialist on the one hand, and the various activities of domiciliary midwifery (midwife, clinic, health visitor) on the other hand, that is required both for the establishment of continuing clinical control and for effective teaching and research. Indeed, it is obvious that in a teaching centre the public health and the clinical and academic aspects

cannot be separated without loss to all. In the previous communication containing these proposals I stated that this collaboration would "at once identify them [the teachers] with those wider social activities of the health authority that are related to mother and child, such as mothercraft, nutrition, health education, etc., and thus open out a new era in the history of the schools. It at once establishes the professor as a professor of health in the wider and creative sense."

The scheme I have just described gives expression to the principle frequently enunciated as one of the aims of the new Health Service—namely, the bringing of the influence of the university and teaching school to bear on the formulation and guidance of public health policy. There is no sphere in which it can operate with more profit both to State and to school than in that of maternity and child welfare. It may be justly described, moreover, as outlining the only manner in which in the process of natural evolution the boards of governors, the medical school, and the local authority must seek to achieve collaboration for their common ends.

Collaboration and Control

In the sense that the board of governors of a teaching hospital or hospitals has a jurisdiction that covers a restricted area the contracts to be entered into for these common purposes can be made with relative ease and with a minimum of readjustment on the administrative plane. In the case of the regional board, on the other hand, the large territory and the multiplicity of local authority, and thus of independent maternity areas with which they deal, necessarily imply a greater range of such administrative readjustment. But the problem remains essentially the same—namely, collaboration between the various local authorities and the hospitals and specialists serving their needs to procure continuity of supervision and control from the domiciliary service (including midwife, clinic, etc.) throughout and up to the hospital in each of the discrete maternity areas included within the region.

The detailed administrative arrangements might well vary in different areas, as was the case in the successful maternity services that existed before the Act. In the proposals which I have elsewhere put forward the control was, by mutual arrangement between local authority, school, and hospital, placed in the hands of the university professor. In a non-teaching centre the contract was made between hospital and local authority, the control being exercised by a senior member of the hospital staff. Under existing conditions similar results would be obtained by suitable mutual arrangements, financial and other, between regional board and local authority and, in a teaching area, between board of governors, school, and local authority.

Under the new provisions, although the antenatal care of normal cases is placed by statute in the hands of the local authority, it is well known that maternity hospitals reserve the right, which they cannot abrogate, to carry out the antenatal supervision of the normal cases which they admit for delivery. This anomaly would naturally largely disappear by the unification of the arrangements for the disposal and control of all women in the area.

The administrative arrangements necessary to regulate the general practitioner's part in the maternity service present considerable difficulty. At the outset it is clear that the stability of such a service as I have described would be gravely impaired unless all the members of the team were prepared to work smoothly with the higher interests of the service as their sole guide. I have already indicated how the general-practitioner obstetrician can in a well-organized

service perform important duties at the clinic, in the home, and sometimes in the hospital. It would be unfortunate if, in a matter which is confessedly difficult and even delicate, we should through lack of the spirit of conciliation and statesmanship fail in our effort to reach the aim accepted by us all as the ultimate desideratum—the unbroken continuity and singleness of control of the woman throughout the whole of her time of pregnancy, labour, and puerperium.

Conclusion

The scheme here put forward does not claim to present more than an outline of the administrative adjustments required to give it effect. It may be objected that by placing the immediate administrative responsibility for the maternity area on the hospital specialist or the university professor in his dual capacity as an officer of the board and local authority it throws upon him heavy duties which may conflict with those he has to carry out for his board, school, or hospital. It is, however, implicit in the argument which I have adduced above that the wider functions which he should rightly be expected to carry out in relation to public health and, in the case of the professor, to teaching and research can find their full expression only by such means. At the same time it is clear that much of the administrative day-to-day detail would inevitably fall to be performed by officers specially deputed for the purpose.

It would be implicit in the scheme, also, that a maternity and child-welfare committee of each area with representatives from board (regional or board of governors), local authority, and executive council would be set up to initiate and guide policy.

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THE PSYCHOLOGY OF THE SURGICAL PATIENT*

BY

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It is characteristic of the mature surgeon not only that his management of a case is based on a sound knowledge of pathology but that his clinical experience has given him an empirical but none the less valuable understanding of human nature. It is because he has taken into consideration all the factors—surgical, pathological, and human—which may affect the outcome that he sometimes obtains a better functional result than a junior colleague whose theoretical knowledge and operative technique are more polished than his own. In diagnosis and in preparatory and post-operative treatment he has learned to think of the patient as a functioning unit in which each component makes its contribution, however indirect, to the health of the whole.

Mind and body are interdependent, and when any serious surgical procedure is contemplated the patient's attitude to his disability must always be considered, and its probable

effect on the outcome. For if psychological factors do not demonstrably affect the leucocyte response or the speed of bony union they can undoubtedly augment or destroy the will to live through severe shock or prolonged sepsis. They may influence profoundly the patient's keenness to regain normal muscular function when the plaster is removed from a fractured limb. No surgeon will embark on a prostatectomy without a careful assessment of renal function, and this may have to be improved before the main operation is performed. In the same way no reparative procedure requiring the patient's co-operation in the rehabilitation phase should be undertaken until his willingness and competence to give that co-operation have been estimated. A few bedside inquiries about his attitude to treatment both in the past and at the moment are usually enough. Evidence of poor function in this respect may well be a contraindication to surgery or may call for pre-operative adjustment. If he is to inspire confidence, the surgeon's attitude to his patient must be one of interest and understanding combined with a certain healthy detachment. There is no reason why the making of a few inquiries about the patient's life and personal problems need disturb this relationship.

It is permissible to those in charge of patients with psychiatric disorders to carry out first-aid when it is needed, or even a little minor surgery. In the same way the treatment of transient unhappiness, ungrounded fear, uncertainty, and laziness are the legitimate concern of the surgeon. Their pathological counterparts, depression and anxiety, however, need expert assessment. There is usually little difficulty in distinguishing between the passing gloom, discontent, or worry which is part of the average man's attitude to life, and the irrationally gloomy view of the depressive or the persistent tension of the anxiety state. Such cases are beyond the scope of psychiatric first-aid.

The Patient's Viewpoint

Patients are far more impressed by what the surgeon says to them, by how much he hurts them, and by how much he appears to understand their individual difficulties than by the most skilful arts he can practise on their unconscious bodies. Few can understand the rationale of their treatment, and the comprehension which they lack must be replaced by confidence in those who are caring for them. If too much is not to be asked of this faith the patient should be told in simple terms why he is having the treatment and what he may expect from it. He will want to know if his condition is dangerous, if it is likely to lead to disablement, roughly how long it will last, and whether he is to expect any discomfort. While enough must be said to counter the often too-justifiable criticism, "They don't tell you anything," care must be taken not to convey dangerous knowledge. If ignorance is to be relieved it must be in terms which the patient can understand and is not likely to misinterpret. Given a little information he will be protected from rumours and false information obtained from his anxious inquiries of other patients. Beyond this, if the surgeon can demonstrate that he appreciates his minor difficulties and discomforts and if he can be made to feel that he is being treated as an individual rather than as a case, little more is necessary.

A major operation is a landmark in the patient's life, a point of reference from which events will be measured in time. The surgical intricacies and hazards mean little to him except in terms of hours spent in the theatre or the length of the skin incision. Since he puts his faith in the surgeon and his craft the excursion into the unknown which the operation entails acquires a magical quality. Once

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