DOMICILIARY MIDWIFERY AND THE FAMILY DOCTOR

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Doctors all over the country are perturbed by the recent report of the Royal College of Obstetricians and Gynaecologists, whose findings obviously point to the establishment of a specialist midwifery service in which the general practitioner would be excluded from midwifery practice unless his qualifications conformed to conditions, not laid down by the General Medical Council, but by the Council of the College. They ignore an issue which has not so far been effectively put before the medical profession—namely, the proper position of domiciliary midwifery in the proposed National Health Service.

The whole position of domiciliary midwifery has in recent years been obscured by the housing shortage. The increased hospitalization of expectant mothers within this period is regarded by most obstetrical specialists as due to an increasing desire on the part of pregnant women for hospital care during their confinement and post-natal period, whereas a very large proportion of the women who have had experience of both hospital and domiciliary care would prefer the latter had they proper homes to live in. Much done-in medicine to-day ignores the patient as an individual and the vital importance of his or her environment. Those ignorant of general practice fail to realize the reactions of the latter upon the individual and upon the family. The following article has been written in support of the doctors in the country who are doing domiciliary midwifery, and who wish not only that they themselves should continue but that their successors should continue what they regard as the most important part of general practice. We have also tried to show that many of the adverse criticisms of our work as practical obstetricians has not the support of recent investigation.

For a number of years, owing to the rapid development of the public health service, local authorities and many specialists have come to think only in terms of institutions and clinics and have failed to appreciate the basic fact that a successful health service must centre round an efficient general medical service. In no department of medicine is this latter fact more evident than in the practice of midwifery, where, with the general practitioner as a centre, you have on the one side the midwife, the district nurse, and the health visitor, and on the other the specialist and the maternity hospital; the combination of all, as illustrated in the terms of the Maternity Services (Scotland) Act, 1937, produces the ideal maternity service.

The provision of better trained and more efficient nurses, the facility of transport, and the prevention of complications by more careful ante-natal examination, have in recent years diminished the dangers and sufferings of pregnancy and labour, and, while reducing the anxiety of the midwife, family doctor, and specialist, have increased their capacity not only to deal with normal maternity cases but to anticipate complications and overcome difficulties to the ultimate advantage of mother and baby. Under the Maternity Services Act the family doctor has already realized that the more careful and skilful his ante-natal examination is the less trouble he has at the confinement.

Maternity practice is the very root of general practice; it produces the bond which unites the home with the family doctor, and the knowledge gained by the practitioner as family doctor not only compels him to see a maternity case in its true perspective, but is one of the main guides in ante-natal diagnosis towards a realization of his own capacity and his own limitations. To the obstetrical specialist the maternity patient is often little more than a case; he fails to realize that successful midwifery can be based only upon a co-operation between every factor which has for its ultimate aim the safety of mother and child. No clinic can take the place of the family doctor.

Exaggerated Fears

The dangers and difficulties of midwifery practice have of late years been magnified out of all proportion by specialists and public health officials. We contend that successful midwifery depends upon a sense of confidence and an absence of fear in the mind of the prospective mother. In the Scottish Report on Maternal Morbidity and Mortality, page 24, it is written: "There has been an unfortunate tendency of late to over-emphasize the dangers of child-bearing, and it is desired to take this opportunity to stress publicly the facts that pregnancy and parturition are natural physiological processes, and that departures from the normal occur only in a small proportion of cases. It is difficult to assess the reactions caused in women by fears unnecessarily aroused by indiscreet public emphasis upon accidents of child-bearing. There is no suggestion that scientific inquiry should be discouraged, but it is believed that disproportionate publicity of untoward results may itself aggravate a problem already sufficiently difficult." A resolution in practically identical terms received the approval of one Representative Meeting of the B.M.A.

The case against the general practitioner's ability to practise midwifery successfully was based on evidence much of which has been proved wrong. The old belief that he is the main agent in spreading infection was long in dying; indeed there are still medical officers of health who have little knowledge of midwifery who hold this view. No reliable evidence is now put forward to support their case against us. In the large majority of domiciliary midwifery cases puerperal sepsis is infrequent, in spite of the fact that the family doctor is daily in contact with all manner of infectious diseases. On the other hand, such diseases as mastitis, phlegmasia alba dolens, etc.—diseases contracted as a result of labour or early in the puerperium, but which come to light some eight to ten days after the confinement—are much more common in hospital practice than in general practice. Want of an efficient system of follow-up prevents this fact being brought home to hospital staffs.

Use and Abuse of Forceps

It is unfortunately true that in the early years of the twentieth century there was too much "meddlesome midwifery." All are agreed that forceps were frequently used when they should not have been. As a result of a campaign against this evil, in which the general practitioner received much abuse from certain specialists, many go to the opposite extreme and fail to use forceps when their use would save suffering and even the loss of infant life. No experienced general practitioner would permit a prolonged second stage of labour when the suffering, superintention of shock, and trauma of the mother, perhaps her life, and the life of the infant could be saved by a few minutes' skilful use of forceps. Not long ago a general practitioner objected to the use of the word "interference," writing that "skilled conduct of midwifery is the ability to use skilled scientific methods when required." The experienced general practitioner has to tackle many cases which are beyond the capacity of the midwife, outside the sphere of the specialist, but which he is quite capable of dealing with successfully. Some time ago Dr. W. H. M. Wilson pointed out in these columns that the impaction of the head in the middle of the birth passages was a common cause of delay in labour, and that if this were realized "the conservative use of forceps would be an everyday matter and not a cause of horror, as it seems to be." He further wrote that "the country practitioner is now, as he had always been by force of circumstances, the acknowledged expert in cases which, without being abnormal, are really difficult."

Until quite recently injuries, particularly tears of the cervix, were put down to "meddlesome midwifery and hastily conducted labours," and, of course, the general practitioner had to shoulder most of the blame. Investigation has now proved that a very large proportion of tears of the cervix are the result of the forces of an uncontrolled Nature. Many of these tears are due to neglect to give analgesics when the os is dilating. In England, under the Midwives Acts, this is very common, but it is less common in Scotland where the doctor is in control of the case. A drug such as pethidine will help to relax a cervix early in labour and thus prevent its injury;

an anaesthetic with manual or instrumental help will save many a perineum. Midwives in Scotland under the Maternity Services Act are much more likely to send for the doctor to repair a torn perineum than are midwives in England, where the ridiculously low figures recently published for perineal tears in cases conducted by midwives make it clear that the latter are not sending for the doctor when they should. Under the Scottish Act the services of an anaesthetist are provided; this guarantees that in extensive tears repair will be more efficiently done.

Ante-natal Care

A big percentage of doctors were doing a large amount of ante-natal work long before this was undertaken by special clinics. Under the Maternity Services Act all medical practitioners are expected to carry out a minimum of three ante-natal examinations in every case they book. The public are becoming much more alive to the importance of ante-natal examination, and within two years of the inception of the Act the medical officer of health of Lanarkshire was able to report that 95.3% of mothers within his area had received ante-natal care.

The ideal place for ante-natal examination is the home of the patient or the surgery of the general practitioner. There is a real danger in the ante-natal clinic. In many cases the patients are scared by their waiting-room companions before they enter the clinic proper; when there, the listening to discussions between physicians, nurses, and students often adds an alarming element of dread to the thought of the coming confinement. It is wrong to discuss ante-natal findings and their possible treatment before prospective mothers, especially primiparae. Ante-natal examination calls for experience and skill, and, as one writer put it, "patients must be individualized in regard to diagnosis and treatment . . . there should be no such thing as mass production."

The purposes of ante-natal examination are to determine the fitness of the patient to carry on with her pregnancy, to educate and reassure her, to diagnose the relationship between her and her infant, and, within the bounds of possibility, to foresee the nature of the confinement and determine whether the case can be dealt with at home or should go to hospital. As in the case of all beneficent advances in medicine, ante-natal care carries with it certain dangers. It has been proved that among a considerable number of the younger, inexperienced obstetrical specialists the ultimate effect of various findings tends to be exaggerated, patients are alarmed, the power of Nature to overcome difficulties is forgotten, and measures are taken which may result, and have resulted, in the loss of maternal and infant lives where, had the case been left to Nature or in the hands of a general practitioner, all would have been well.

For some years the widespread and unnecessary use of Caesarean section or of induction of labour for difficulties which Nature herself, or the general practitioner in the quiet of the patient's own home, could overcome led to protests from influential quarters. Dr. Bright Bannister (1935) wrote "that the operation of Caesarean section occupies an unjustifiable position in obstetric practice to-day, that the incidence of the operation is far too high, and that it is attended by a mortality which makes it suspect among measures that should have for their aim the diminution of maternal mortality." Prof. F. J. Browne (1934) was equally emphatic when he wrote that "no one will deny that much of this intervention is unnecessary" and added, "I believe I am justified in saying that ante-natal care has often simply transferred mortality from one column to another."

Whether we have to deal with a case of toxæmia, disproportion, hyperemesis gravidarum, heart disease, or any of the other complications of pregnancy, no one is so fitted as the family doctor, knowing as he does the personal and family history of the patient and the patient's home conditions, to determine whether the case should be dealt with by himself and in the patient's own home or transferred to hospital. The most careful and experienced, be he general practitioner or specialist, can make an error of judgment in midwifery practice. This does not happen in the commoner difficulties, but in sudden and unforeseen emergencies; and even in the big majority of these cases the specialist can be called to the home

of the patient and, with the assistance of the family doctor and nurse, deal successfully with the case.

It is possible that much of the present urge for institutional treatment is a passing phase and depends in large measure on the wretched housing of the majority of our working people. Hospitals we must have, but the ideal midwifery of the future must be based upon the principles which form the foundation of the Maternity Services (Scotland) Act, 1937—that is, close co-operation between general practitioner, midwife, specialist, and hospital.

Relief of Pain

The relief of pain in labour is of supreme importance to a large percentage of parturient women. It is the psychological build of a woman which determines her appreciation of pain, and from this point of view the family doctor, with his previous intimate knowledge of the woman, is in the best position to decide when an anaesthetic should be administered. In Scotland and England under the Midwives Acts midwives were discouraged from sending too often for the doctor. The Maternity Services (Scotland) Act recognizes the importance of relieving pain; the services of an anaesthetist, if necessary, are provided. In England specialists are advocating that midwives should have permission to administer anaesthetics; in Scotland we hold—and we are supported by the B.M.A.—that no midwife should be allowed to administer an anaesthetic without a general practitioner being present. It is very gratifying to note that in England, where in the past the relief of pain in labour was less considered than in Scotland, the insistence of the patient on obtaining relief of pain is resulting in more frequent calls by the midwife on the doctor.

There is no one in a better position to give valuable information regarding maternity nursing than the G.P. His opinion is never sought. It would be well were the Council of the Royal College of Obstetricians and Gynaecologists to appreciate the fact that a registered medical practitioner is a practitioner, and a registered nurse is a nurse, and apply this knowledge to the practice of domiciliary midwifery.

Queen's nurses have for many years, under the direction of the family doctor, conducted midwifery in the most satisfactory way, with efficiency, tact, and discretion. The outstanding feature of their service is the traditional co-operation between nurse and doctor. The midwife who has had a general nursing training has also these qualifications. In the training of midwives there is great need for instruction in ethics in order to impress upon them the importance of avoiding idle talk and discussing the condition of their patients with them. A patient must have perfect confidence in her nurse as in her physician. The longer a midwife remains in a district the better, for she gets to know her patients and they come to have confidence and trust in her. Local authorities tend to think too much in terms of institutions and too little in terms of the mothers' own homes, with the result that the changes of nurses are too frequent.

In maternity practice midwives do not seek medical aid sufficiently early and often. A nurse should realize, especially in cases of primiparae, the importance of sending for a doctor early in labour. When the os is dilating the doctor is able to lessen the patient's pain without injury to the foetus, and also to lessen the chance of injury to the cervix; he is able to allay the fears of the patient and her relatives and to guide and encourage the midwife.

The Teaching of Midwifery

Howat in the *Lancet* (1938), in discussing the many conflicting theories in well-known textbooks, remarked: "With teaching so copious, so various, so conflicting, confusing, and mistaken, choice is wide and perplexity almost inevitable. In fact, it is not so much the fault of the general practitioner that his obstetrical skill is under a cloud as the fault of his teachers. . . . Their published writings go to show that British teachers of midwifery to-day, almost without exception, hold and teach not that normal parturition is a normal function to be naturally performed so long as it progresses normally, but that it is a process calling for active interference." We might add that in many teaching centres students are strongly advised, in cases where there is the slightest deviation from the normal, either to

call in a specialist or to send the patient to hospital. Such is the modern training.

General practitioners who, during the past ten years, have read articles upon midwifery, followed discussions upon antenatal care, etc., and appreciated the conflicting views expressed are not surprised to find that some obstetricians are uneasy about their ability to teach midwifery successfully to their students. Happily physicians have not the same feeling about their teachers of medicine and surgery, and yet, after all, a much greater part of their surgery work requires reference to a specialist. The obstetrical specialist and the G.P. always approach the subject from a different angle. General practitioners as a body are very conservative, and this has been their salvation, or rather the salvation of their patients, when faced with the ever-changing teaching of the specialists.

According to some obstetrical specialists the perineum is a danger spot which must not be touched during the course of labour; vaginal examination is almost an obstetric crime. We general practitioners examine our patients per vaginam as often as we think necessary, and it is comforting to be told by a well-known obstetrician that he has still to be convinced that digital vaginal examination is a danger to a woman in labour, and that "he was prepared to argue that anyone who has not sufficient knowledge to make an examination in a surgically clean manner has no business to attend a confinement." Within recent years no new era has dawned upon hospital and specialist obstetric practice, the outstanding factors in the reduction of maternal mortality being sulphanilamide therapy and blood transfusion.

By far the best method of learning midwifery practice for both doctors and nurses is the direct one—that is, to sit at the bedside of a woman in labour. Attendance at many normal labours is of the greatest help when it comes to tackling the difficult and abnormal case, and it would assist the hospital specialist and hospital practice if the specialist gave more attention than he does to the normal and itched less to interfere with the course of Nature. We would like to point out to those obstetricians who have been so prominent in belittling the general practitioner's ability to practise midwifery successfully that they would have gained considerably in manipulative skill, and also gained a real knowledge of the parturient woman, if, before they had specialized, they had spent a few years in general practice. Then they might have appreciated the many difficulties the family doctor encounters in his daily work.

Conclusion

We would assure Mr. Eardley Holland (*vide Practitioner*, January, 1945) that the team-work upon which, he contends, the successful practice of modern midwifery depends will be found in Scotland where the Maternity Services (Scotland) Act, 1937, is in operation, and that there is no tail. This Act has changed the whole future of maternity practice in Scotland, and England would be wise to follow our lead. It is hardly necessary to add that in the proposed National Health Service the maternity services would not be under the direction of the local authority. The psychological effect of the presence of friendly and sympathetic people in familiar surroundings upon a woman in labour cannot be overestimated. Domiciliary midwifery, with the woman in the hands of a doctor and nurse in whom she has confidence, is safer for mother and infant, in all but a small minority of cases, than institutional midwifery. When the housing shortage has been remedied there will be a great increase in domiciliary midwifery to the advantage of the whole country.

Finally let us quote two outstanding medical women. Dame Janet Campbell writes: "No woman ought to lack, on account of poverty, anything she needs during childbirth. The great thing is to make midwifery in the poorer houses sufficiently attractive for the family doctor to take it up and study it more closely." This has been done in Scotland. Dame Louise McIlroy writes: "There were those who considered that the mothers of the country would be best served by a whole-time midwifery service, and the general practitioner would have to go, but it seemed a pity, for the general practitioner provided a human element lacking in a different service. Take prevention, which was the slogan of legislators; there was no one more capable of instituting preventive measures than the family

doctor. He was the first line of defence, knowing the family and its circumstances, treating the little ailments of the prospective mother, and forestalling complications."

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AGENDA FOR PLANNING LONDON HOSPITALS

KING EDWARD'S FUND PROPOSALS

Yet another report on London hospitals, this time the work of a joint committee of King Edward's Hospital Fund for London and the Voluntary Hospitals Committee, makes its contribution to the solving of the largest if not the most difficult of hospital planning problems. It runs parallel with the recent survey of hospital services by Dr. A. M. H. Gray and Dr. A. Topping (reviewed in the *British Medical Journal* of July 14, p. 56) and reaches substantially the same conclusions.

It is now generally recognized that the hospital services of London cannot be planned without taking into account the extent to which the Home Counties look to London for hospital facilities. Before the war about 40% of the patients treated in the voluntary hospitals of London came from outside the County of London boundaries. There is a continuing tendency for the London population—its industries as well as its homes—to move outwards; means of transport between the centre and the periphery have improved out of all knowledge; but hospital provision has not shared this tendency to any great extent. Even if, in future, large additional hospitals are put up in the outer areas the great hospitals of Central London will still be looked to for highly specialized services.

The area of London and the Home Counties must, therefore, be planned as a whole. It can be divided roughly into three zones: the central area with a heavy concentration of beds and a declining residential population, the industrial and dormitory area with a shortage of beds and a rapidly increasing population, and the more rural areas centred on local towns. The hospitals in this great region vary much in size and function. The local authorities have a number of large, up-to-date, and well-equipped hospitals side by side with old-fashioned and unhygienic institutions still administered under the Poor Law. On the voluntary side there are hospitals ranging from the very largest to small ones of 60 beds or so, which, however, have been classed as general rather than as cottage hospitals.

Hospitals in Transition

The report discusses the transition from the cottage to the general hospital. Such a transition implies that the general hospital will lay itself out to deal with the whole range of "acute" work likely to arise in its locality. It must provide a consultant staff with clinical responsibility for the patients under their care, a resident medical staff, a nursing staff of the required competence, all proper ancillary services, out-patient clinics, and the commoner special in-patient departments, such as ear, nose, and throat. Efficiency demands a bed complement somewhere in the neighbourhood of 150, and a hospital with 150 beds should afford sufficient work to warrant the employment of at least three resident medical officers, in addition to one or more registrars.

"It would . . . make for progress if it were recognized that a hospital with less than 150 beds—other, of course, than a cottage hospital staffed by general practitioners—is unlikely to be able to provide a complete service, and should therefore be regarded as in a state of transition, and as not yet having fully attained to the status and responsibilities of a general hospital."

It is common ground that it is not yet practicable to propose that all the members of staffs of the smaller general hospitals, and even of some larger hospitals in the Home Counties, should be consultants, giving their whole time to general medicine or surgery or to a specialty; but it is desirable, say the authors of this report, that in future such appointments should be restricted to practitioners who have served for a period of not less than two years in a hospital or unit devoted to the special work they propose to undertake.