into the composition of compound liquorice powder, which is a useful regular laxative in children. Castor oil is more of use as an occasional purgative than as a regular laxative. It often acts well, however, for the latter purpose in the case of constipation in elderly patients. It may be given either in capsules (20 minims), two or three at bedtime, or mixed with an equal quantity of glycerin in such dose as is found suitable.

Spastic Constipation

General Management.—As this form of colon disorder tends to occur especially in neurotic subjects with irritable or exhausted nervous systems, rest is usually indicated. In severe cases it may be necessary to send the patient to bed with hot applications to the abdomen to allay pain. In milder cases it may suffice to send him away for a holiday or merely to rearrange his day so that he gets more rest. Abdominal massage is contraindicated.

Diet.—The diet must be the reverse of that for the atonic form of constipation, all "roughage" being as far as possible eliminated. Raw fruit and vegetables should therefore be avoided, and cooked vegetables taken only in purée form; cooked fruits should be sieved. White bread must take the place of brown. Fats are useful, and should be taken freely if the patient can tolerate them.

Drugs.—The mechanical aperients are the most suitable, or one of the milder of the anthracene group, such as an infusion of senna pods. Belladonna should be given to relax spasm, beginning with 5 minims of the tincture two or three times daily and increasing it if necessary. It may also be given in the form of the extract, 1/2 grain in pill, night and morning.

Enemata.—If the spasm is in the sigmoid an enema of 6 oz. of paraffin or olive oil may be run into the bowel and left there all night, a pad being worn to prevent soiling. It may be gently washed out next morning with warm normal saline.

Dyschezia

Dyschezia or rectal constipation enters into most obstinate cases of the disorder, especially in women in whom the abdominal wall has been left weak after childbirth. Such patients can only empty the bowel if its contents are first made fluid by a large dose of aperient. In order to avoid this one should only prescribe such a dose of laxative as is sufficient to bring the contents of the bowel down into the pelvic colon and then remove them either by the aid of a glycerin suppository or by the injection of not more than half a pint of plain warm water, which may be done either with a pear-shaped rectal syringe or a ball syringe.

WHITHER MIDWIFERY?*

BY

E. FARQUHAR MURRAY, M.D., F.R.C.S., F.C.O.G.

PROFESSOR OF MIDWIFERY AND GYNAECOLOGY, UNIVERSITY OF
DURHAM COLLEGE OF MEDICINE, NEWCASTLE-UPON-TYNE

During recent years there has been a determined effort to make the subject of maternity one of paramount importance. Official statistics have convinced the general public at last that something is radically wrong.

Anyone on the staff of that peace-time casualty station, a maternity hospital, has abundant evidence that many pregnant women do not get proper medical supervision, that many recently delivered women do not receive adequate nursing, and that there is a deplorable lack of co-ordination and co-operation between the medical and nursing services concerned. This is a criticism not of doctors nor of midwives, but of a system.

The Newcastle Policy

Fortunately in their early efforts to improve matters the local health authorities sought the assistance of consultants, academicians, and honoraries from the staff of a maternity hospital. Had it been otherwise the policy of the Durham school might not have come into being nor this address have been possible.

The local consultants were invited to act in a consultative capacity for puerperal pyrexia, or to run ante-natal centres, either as ante-natal officers or as consultants. The demand was enormous, and at one stage could not be met. The duties entailed were in one respect purely expert and consultative, and in others well within the scope of general practitioners. The position was embarrassing and difficult because it was felt at that time that failure to meet the demands would or might result in a whole-time officer being appointed, thus cutting off a wide field of consultant practice.

At this stage a clear definition of the relationship of consultants towards the project, with special reference

to their academic, institutional, and private interests, was demanded. It was agreed that in any rate-paid service providing consultations with doctors the consultants would form a panel, which would give the doctors freedom of choice. Such a policy has governed all agreements entered into during the past ten years for providing expert advice for general practitioners at centres, or in the patients' homes, or at the consultants' rooms. Certain earlier agreements not in keeping with this policy are in the process of being corrected.

Consultations in Puerperal Pyrexia

A start was made with consultations in cases of puerperal pyrexia. This was both educative and stimulating. Hitherto consultants had seen these cases only at the maternity hospital; now they were able to see them at an earlier stage, and to appreciate the difficulties with which the general practitioner has to contend. Making full allowance for the value of expert advice, it was only too obvious that what the patients needed most was good nursing and not consultants.

These consultations were obviously provided to popularize the notification of puerperal pyrexia as opposed to the old and mainly ignored notification of puerperal fever. Only those actively engaged in the work can appreciate that nursing, not notification, is the solution of the problem.

This freeing of expert service from the confines of a maternity hospital for patients of the hospital class suggested the need for expert service being available at all stages and for all conditions. The bulk of midwifery was dealt with in the patients' homes, while the services of specialists, outside a maternity hospital, were only available for patients of the wealthier classes. The faults of the existing system were flagrant and required remedying. Pregnant women too ill to travel were sent by ambulance to hospital to get expert advice. "Failed forceps" cases were all too frequent admissions, while women developing complications during the puerperium, even in areas where the health authorities had arranged for expert advice in cases of puerperal pyrexia, were unprovided for because the complication was apyrexial.

* Being the substance of a paper read before the North of England Branch of the British Medical Association, December, 1935.

Another aspect, and one too readily overlooked, was that many women are particularly sensitive at this time, and dread the publicity and the possible presence of students at hospitals. A further matter of vital importance was that many women were lost every year owing to the absence of any provision to combat shock and haemorrhage, which any doctor may have to contend with in a working-class house. Expert advice and, still more important, the necessary adjuvants, are usually lacking; the only possible alternative is to send a shocked and exsanguinated patient to a maternity hospital.

Maternity Emergency Service

In the *British Medical Journal* (April 13th, 1929, p. 691) I advocated a comprehensive scheme of expert service to meet all these points. Several health authorities have since adopted the proposals, and offer doctors the advice and, where necessary, the operative assistance of experts for patients of the hospital class, at all stages and for all conditions in their homes. Some have agreed to the suggestion regarding sensitive patients, and allow doctors to send patients who are fit to travel to have private consultations on ante-natal or post-natal conditions at a special fee, which is paid by the health authority. Lastly, an emergency service has been organized, and has been adopted by the Health Committee of Newcastle, whereby any doctor faced with a grave crisis can, by 'phoning the maternity hospital, have at his disposal within a very short time a nurse, a complete outfit for combating shock and haemorrhage, and if necessary an expert. In the Newcastle area, Wallsend was the first public authority to provide, in 1929, expert advice and assistance at all stages and for all conditions either in the patients' homes or, where desirable, at the consultants' rooms. Newcastle-on-Tyne, in 1935, was the first to adopt the emergency service scheme. Newburn-on-Tyne, in the same year, adopted the complete scheme of expert assistance both for routine and for emergency work. As regards the outlying areas, Northumberland County accepted the comprehensive scheme almost in its entirety in 1929, and will have the complete service, including the emergency service, in the near future. Durham County has arranged for expert advice for cases of puerperal pyrexia. The area supplied in this respect by the Durham school, so far as expert service is concerned, extends sixty to seventy miles into Northumberland County and forty to fifty miles into Durham County, as measured from Newcastle.

The General Practitioner

As regards the general practitioner's place in the new order it was obvious that this was apt to be overlooked. It was almost inevitable that in the early stages ante-natal centres should be staffed by whole-time officers or specialists, and here and there an individual practitioner, this last being far from popular either with the health authorities or with the general medical community. However staffed they had the great defect of widening the gulf between doctors and midwives, the latter thereby acquiring an enhanced position by being made even more independent of the local doctor. Hitherto midwives could not get organized medical supervision of their cases, as they were only able to seek medical advice when one or other of their rules became operative.

Propaganda was essential because the work was not being done effectively, but the fault was just as much attributable to the medical schools, the health authorities, and the midwives as to the doctors. If, as seemed likely, the profession was to be still further isolated from the preliminary stages of a responsibility which they might be called upon to assume at the request of a midwife, then some policy was called for.

In 1929 I and my colleagues initiated a policy which may be regarded as the policy of the Durham school. The essential features were as follows. The consultants would guarantee attendance at the centre which it was proposed to open. They would attend every week to start with, then fortnightly, later monthly, and retire at the end of a year, to be available—on a panel—as consultants to the service. The local doctors who wished to take part would be invited to attend during the consultant session and would receive instruction in ante-natal care, but as soon as possible they would be given their own day and hour of attendance, to which the consultants would refer those cases which they saw on the routine day. The midwives would also be notified and encouraged to bring their cases, and it would be arranged that the subsequent ante-natal care would be carried out by the doctor who would be called in if complications arose.

The scheme was given a trial at Wallsend in 1929, and there has been since then a regular clinic attended by a team of local doctors. A similar procedure was carried out at Ashington, a large colliery town, with equal success, and recently at Newburn, also a colliery town. At Gosforth, a suburb of Newcastle, the work was slowly transferred by an individual consultant into the hands of general practitioners, and the consultant service of an open panel was adopted.

While the policy was at work it was obvious that it was not universally applicable or even desirable. The medical officer of health for Tynemouth studied the policy and adopted the consultant service, but developed a system of attendance of the local doctors at the ante-natal centre (the hospital) without the aid of consultants. In other areas, such as Blyth, a busy seaport town, the medical officer of health has depended more on the doctors and less on a centre, but has placed the consultant service at the disposal of the doctors.

Here, therefore, we see the problem of providing an efficient maternity service tackled in various ways. Each has points to commend it, each has points which are subject to criticism. Certain practical points must be considered, not only from the viewpoint of the service as it was some years ago but even as it is to-day.

Maternity Centres

When these centres started nobody really cared and nobody really knew what was intended. Shops, halls, and odd types of accommodation were rented. They were well staffed and, in many, an additional attraction such as free milk was offered. The profession, like the community, had emerged from the great war, and that part of their professional work which their training and war service had least prepared them for, maternity work, naturally suffered. They could not, and did not, see what was happening. The view that someone should look after the women whom keen and competent doctors in industrial practice were never asked to see, except when complications arose, seemed reasonable, but nobody had hitherto been asked or encouraged to take an interest in these cases.

Then there was a slow awakening. The centres as a hub of maternity service altered in their character. They became attractive buildings; some were originally so. They offered examination facilities, nursing assistance, and some sort of organization. In some respects they excelled even the maternity hospitals.

Such examination facilities have, as a result of this policy, been placed at the disposal of the doctors at Gosforth, Ashington, Newburn, Wallsend, and Tynemouth. Centres are not essential in every area. In some industrial areas the doctors have their special day set apart for this type of work. Centres have their value;

the value is greatest in industrial areas, least in better-class areas, and negligible in country areas.

During the period under review, which includes perhaps the last fifteen years, much has happened. Medical schools have extended and intensified their undergraduate and post-graduate training. Recently qualified graduates are forming queues hoping for appointments at maternity hospitals. A British College of Obstetrics and Gynaecology has come into being, and offers a diploma and a membership by examination, and a fellowship by election. The senior Colleges of Medicine and Surgery have given the new College every possible encouragement and support. The professional atmosphere has completely changed towards the subject. An added interest is being taken in it because there are signs that some attempt is being made to remedy the defects of the old system and to make this form of medical service more attractive than it has been in the past.

Some Criticisms

Before venturing on a grave criticism of some existing schemes it is important to realize what has happened as regards the nursing side of the question. To-day, as in the past, it is shockingly inadequate. Some areas have no midwives, whilst in others the sole help is the district nurse, who has probably numerous septic dressings to attend to. In districts where there are midwives it is humanly impossible for a popular midwife to guarantee the necessary nursing, certainly to a case of incipient sepsis. Her livelihood is at stake, especially if she is suspended from her practice. There are numerous nursing associations which are giving excellent service, but even with their assistance the position is still hopelessly behind the times or the needs.

Midwives as a class are, in the writer's opinion, just as disappointed and discouraged as the medical profession in regard to this problem. This is shown by the fact that since the authorities increased the period of training of the pupil midwife, with no previous general nursing training, from six to twelve months, and only permit women with previous general training to sit for the C.M.B. after six months' training in a maternity hospital, the former class of pupil midwife is disappearing, and the majority of the latter have no intention of practising midwifery, but hope merely to obtain a higher qualification or a post as a health visitor. Only a small proportion of the present-day pupil midwives who receive lectures from academic teachers and use up a vast amount of clinical material, to the detriment of the students in training, have any intention of practising as midwives. This is fundamentally wrong.

When the position is viewed by a member of the teaching staff of a medical school and a maternity hospital it is time to rebel at what is going on, and to urge that a halt should be called. The medical schools of this country have an opportunity to help in this matter by moulding the present urge in the right direction, and by acting as foci from which the future efficient service in this work can be developed.

Maternity Service of the Future

Replies to a questionnaire recently sent to the medical officers of health in the leading medical school centres revealed the following facts, which should make those who teach and examine students and pupil midwives think seriously. In four large medical school centres in this country the students, after qualifying, will find that the ante-natal care of a considerable portion of their clientele is carried out by individuals whose salaries are guaran-

teed, whose hours of service are limited, and who never have to face the realities of the subject. In some instances they will find that their work is being done by specialists. On the practical side they will find that they still have to work with handywomen, or that the midwife they usually work with simply cannot carry out the intensive nursing they would like a patient to have without endangering her economic position. They may at the same time notice that some of the women who were pupil midwives at the hospital where they received their practical training are now health visitors in attendance at centres.

The maternity service of the future must, as in the past, depend for its success on general practitioner obstetricians. It is a great mistake if they are not encouraged and given every possible facility for taking an active part in the work. The nursing service provided is inadequate, and the present position of doctors as stand-bys for midwives is undignified and not in the best interests of the patients concerned.

What has been accomplished in the Newcastle area can be done in any other medical school centre. It is, however, merely the first stage towards the ultimate ideal. The matter is urgent, foresight is essential, and the national urge for improvement is fortunately still present. Till the profession makes up its mind one can only repeat the question "Whither Midwifery?"

INTERNATIONAL UNION AGAINST TUBERCULOSIS

CONFERENCE IN LISBON, 1936

The tenth Conference of the International Union against Tuberculosis (secretary-general, Professor Fernand Bezançon) will meet in Lisbon from September 7th to 10th, under the chairmanship of Professor Lopo de Carvalho, president-elect of the International Union. The discussion will be limited to three main subjects: biological subject, "Radiological Aspects of the Pulmonary Hilum and their Interpretation," opening report by Professor Lopo de Carvalho (Portugal); clinical subject, "Primary Tuberculous Infection in the Adolescent and the Adult," opening report by Dr. Olaf Scheel (Norway); social subject, "The Open Case of Tuberculosis in Relation to Family and Domestic Associates," opening report by Drs. C. J. Hatfield (United States) and D. A. Powell (Great Britain). Ten speakers selected in advance from a list presented by the forty-four countries belonging to the Union have been designated to open the discussion on each of the questions on the agenda. The British openers are Dr. L. S. T. Burrell and Dr. W. T. Munro.

The Organization Committee of the conference has prepared a very attractive programme of receptions and excursions; the latter will enable members to visit the chief anti-tuberculosis institutions as well as the most picturesque scenery in various parts of Portugal.

Members of the International Union are invited to take part in the conference free of any contribution fee. They may forward their application either through the medium of their Government or their national organization against tuberculosis, or directly to Lisbon, at the following address: Organization Committee of the Tenth Conference of the International Union against Tuberculosis, Assistencia Nacional aos Tuberculosos, Avenida 24 de Julho, Lisbon, Portugal. Names may also be sent to the headquarters of the secretariat of the International Union against Tuberculosis, 66, Boulevard Saint-Michel, Paris 6e. Persons who are not members of the Union and who wish to take part as "Members of the Conference" must forward their application, together with a contribution of 200 escudos (approximately 125 French francs), exclusively through the medium of the National Association for the Prevention of Tuberculosis, Tavistock House North, Tavistock Square, London, W.C.1. Reductions on hotel prices and railway fares will be granted to members of the congress.