THE TRAINING IN MIDWIFERY OF MEDICAL STUDENTS AND NURSES.

SOME REFLECTIONS AND A SCHEME.

BY

DONALD W. ROY, M.A., M.B., B.Ch.CANTAB.,
F.R.C.S. Eng.

OBSTETRIC SURGEON, ST. GEORGE'S HOSPITAL; VISITING PHYSICIAN,
GENERAL LYING-IN HOSPITAL, YORK ROAD, LAMBETH; EXAMINER
IN MIDWIFERY, CAMBRIDGE UNIVERSITY, SOCIETY OF
APOTHECARIES, AND CENTRAL MIDWIVES BOARD.

In these days when the air is humming with schemes, some of them doctrinaire rather than practical, for the improvement of the maternity service of the country, it is perhaps time for those of us who have been for many years on the active staffs of lying-in hospitals, and are still active and not consultant, to make some observations based on practical experience and reflection. Otherwise it may very easily be too late to pick out a practicable plan in the plethora that will exist.

It is not my intention to write anything much about the general practitioner's part in a maternity service, except as regards his early training. My main concern is with any measures that exist, or that may be proposed, for the improvement of the teaching in midwifery of medical students and midwives.

It ought not to be necessary to point out that, before producing a detailed scheme, some consideration should be given to principles, were it not the fact that some plans have lately been produced which run contrary to important principles, and which, instead of utilizing and building on existing and well-tried foundations, involve financial injury to, or the destruction of, the institutions of highest standing in the training of midwives and all they stand for in midwifery. I refer to the suggestion that the lying-in hospitals of London should be converted into training schools exclusively for medical students. Now as to the principles that ought to lie behind any scheme for improving the teaching of midwives and students very little has, I think, been written in the sense of what I have to say.

Here I must ask for patience while, for the purpose of my argument, I cite some facts which are perfectly well known in midwifery circles.

The Most Satisfactory Method of Employing Midwives and Medical Practitioners.

There is, I believe, substantial agreement in nearly all quarters that the most satisfactory results in midwifery have been obtained by well-trained midwives working in conjunction with medical men experienced in midwifery (be they general practitioners or obstetric specialists). By this means the reliable midwife, if working by herself, conducts normal labour to its completion, calling in the doctor in certain specified conditions or when she is in doubt. If she is working with a doctor she looks after his patient mainly in the early stages of labour, summons him at the time his presence is most needed, but sets him free at other times to attend to the more urgent calls of his practice, so that he need never be forced by pressure on his time to undertake untimely and unnecessary methods of intervention with normal labour. This course is only possible when the practitioner employs reliable and well-trained midwives whom he can trust, and does trust, and not handy-women.

This ideal state of things is, I believe, still found relatively only rarely in industrial areas, where the bulk of midwifery is practised and is seen at its best in the service of some few lying-in charities. But this, or something like it, is surely the ideal to aim at in general throughout the country. One principle is, then, that not only skilled doctors and midwives should be available, but that their training should instil the wish to co-operate in their respective spheres. How is this principle to be aimed at, and, if possible, carried out?

Reasons for Lack of Co-operation between Midwives and Practitioners.

The past history of midwifery in this country is one of many struggles between midwives and doctors for the upper hand, and for, one supposes, the greater share of the loaves and fishes. The passing of the Midwives Act marked the first stage, but only the first stage, in getting a satisfactory maternity service, by ensuring that there should at all events be available, for those who needed them, women who were trained up to the level for attendance with safety to the mothers and babies on cases of normal labour. It is generally admitted that, for the particular work for which they are intended, the training of midwives is more satisfactory than that of medical men. But an unfortunate legacy of past struggles has remained in the considerable degree of distrust and dislike of midwives that still lingers among doctors. This is probably based on the tradition of a struggle between two sets of people for the same work and livelihood, and is sometimes reinforced by individual unhappy experiences. Whatever its reasons, it is found among both doctors and midwives, and causes, in some cases, difficulty in real co-operation between them. It may not be wholly possible to overcome this feeling in this generation, but it is surely necessary to see in what respects the future midwives' and future doctors' training can be modified to improve it, and to raise the whole question of a maternity service on to a higher basis of real co-operation between the two branches which must work together in the future, if its success is to be assured. Mistrust in this case, as in most others, is due to lack of knowledge and understanding of one another in the two parties, and is due in some respects to the growing separation between the training of midwives and that of doctors, which leads to many other disadvantages as well.

Disadvantages of Separate Training for Midwives and Doctors.

The disadvantages that come from this separation may be considered generally now, and will be considered later in more detail. If it is desired to build up in this country a coherent plan for a good midwifery service consisting of midwives and doctors, it should be plain that the teaching of both divisions should be in essence the same, and should come mainly, therefore, from the same teachers under the same conditions. The teaching should be only modified to fit each part of the service for the different role it should play, while ensuring that the two departments of work should dovetail into one another and make a sound joint. Medical students are taught midwifery in all sorts of ways in all sorts of institutions, but the basis of their teaching is what is imparted at the maternity department of the general hospital to which they are attached. Probably the larger proportion of the midwives are taught at institutions, including the Poor Law hospitals, where there are no medical students.

It is probably in the lying-in hospitals, however, rather than in the general hospitals (with some exceptions) that the good and true tradition of teaching sound methods of conservative midwifery now resides, and it is on this sound basis that the present teaching of the best trained student midwives now rests. The general hospital is to a considerable extent, and probably quite rightly, imbued with the idea of the old traditions of treating grave and established medical and surgical diseases, and does not take kindly to the preventive aspect of treatment and the wise guidance of a natural process, which is the life and spirit of modern midwifery. There is also, unfortunately, in general hospitals often an atmosphere of slight disparagement and contempt of midwifery and its practitioners, which soon communicates itself to the student, with bad results on his keenness. Furthermore, it is hardly ever possible to have sufficient maternity beds in a general hospital to give to the student in three or six months a proper idea of the just proportion of normal to abnormal labour, so his training loses perspective either in the direction of the need for too much interference with labour or, more rarely, too little.

The Solution of the Difficulty.

It is therefore to the lying-in hospitals, with their greater resources, that we must look for most help. It

is by extending their activities to embrace the teaching of both student midwives and medical students, and not by separating the two, that a change for the better in the teaching of both can be effected, with its enormous influence for good on the future of a maternity service. There is only one way in which this can be done without inflicting injury on the great lying-in hospitals, with their excellent traditions of midwives' training built up by the devotion of teaching midwives and medical staff over a number of years. For this purpose the activities of the lying-in hospitals must be widened and extended as far as possible, and their surplus of clinical material, which is not in fact at present great, should be used for medical students.

Attachment of Poor Law Midwifery Beds to Lying-in Hospitals.

Secondly, to provide better opportunities for both midwives and students, it will be necessary for each lying-in hospital to have attached to it the nearest or most suitable Poor Law midwifery beds, and to have control of them for teaching purposes, in return supplying the extra teaching facilities for the pupil midwives of the Poor Law hospital. By a plan of this kind not only will the resources of both institutions be available to provide a really satisfactory training for midwives and medical students, but these will be trained together so far as that is possible, and on common lines.

Avoidance of Expense and Difficulty of Providing Nurses.

The nursing difficulty, and the expense of providing it in any institution devoted to medical students exclusively, would be solved by this arrangement. The student midwives could, as part of their curriculum, act as monthly nurses for the medical students' cases during the period in their training when they were not themselves taking cases.

The objection has been raised, and will be raised, that where nurses and medical students are trained together the nurses filch away the bulk of the cases. There is definite substance in this difficulty, which springs from the greater keenness of the nurses to get their money's worth out of what is to them a most expensive training; and it must be added that there is also in such cases the connivance of people whose duty it should be to arrange things impartially. In any case, in the plan I have outlined a new teaching organization would have to be built up, and that point could be readily provided for.

Suggestions for Reorganization of Combined Teaching Institution.

In a scheme of the kind outlined a fairly senior man experienced in midwifery, and also capable of organizing, administering, and co-ordinating the two hospitals, would be needed. He would have to organize the work of this midwifery unit or division, and adjust the claims and spheres of the midwives and medical students; he would have working under him on one side the teaching midwives, and on the other the teaching staff of the students. These teachers would be in some degree interchangeable, with advantage to both sides. At first his duties would be exacting, and a picked man would be needed. His position, one suggests, should be something like that of the registrar of a military hospital in war time—that is, an executive second in command with very wide powers. He should have a direct appeal to the managing body. He would also combine some of the position and duties of a resident obstetric surgeon, corresponding to the resident assistant surgeon at a general hospital. He would take an active part in the clinical teaching with his subordinates, and one or other of them would be always available for that purpose.

Continuance of Honorary or Visiting Staff.

The members of the visiting staff during their times of duty would represent the officer commanding a military hospital, but their role would be chiefly consultative and teaching, and they would constitute a final appeal in difficulties of all kinds. They might also be available for consultative work for different classes in the district served

by the hospital, and might see special ante-natal cases of all classes in a room at the hospital at specified times.

The visiting staff might be found ultimately to be redundant, as the organization found itself, but at first the clinical and general experience of its members would be a valuable restraint in hospital and committee on ill-judged departures, and I think they would continue to be needed. If not, this method would prove a safe and valuable approach to the Rotunda system of a whole-time master, if and when suitable men were available.

Midwifery Teaching Requirements of London.

In London the three largest separate lying-in hospitals—Queen Charlotte's, City Road, and the General Lying-in Hospital—with a neighbouring Poor Law midwifery institution attached to each, would probably cover most of the ground at first. In large towns with maternity hospitals a similar arrangement could be started if it were needed there. From this sort of plan of improved teaching all the other benefits that constitute a good maternity service could be gradually developed, including the practitioner's service.

Disadvantages of Separate Teaching Considered in More Detail.

The disadvantages that come from the separation of student midwives' training from that of medical students may be considered in more detail.

1. From the standpoint of the midwives' training. This is, so far as it goes, good and practical, but, owing to the great variation in intelligence and education of the student midwives, it tends to be too dogmatic and rule-of-thumb, especially that part of it—and it is the main part—at present taught by teaching midwives. The corrective of more teaching in broad principles, to exercise their reasoning powers and teach them to think, is needed. This can best be given by men of wide experience and education, combined with practical obstetric training and examining experience. There is an unfortunate tendency in some midwives to get the idea that their knowledge is in all respects superior to the doctors', and it must be confessed that in some instances they meet with evidence to support this assumption, but only in the restricted field a midwife's training covers. If practitioners and midwives shared as students in some degree a common training, both sides would gain in that better understanding and appreciation of their own and each other's limitations and excellences which comes from working together at a common task under properly regulated conditions. As things are at present the midwife, with her ideas of her knowledge uncorrected by a true comparison with the wider training of a good medical student, often develops *tête montée* and an entirely unwarranted contempt for the doctor, which will lead to trouble later on, especially if she encounters a doctor with some of the ideas referred to earlier in this paper.

2. The medical student loses in many cases at present the advantage of learning at least some of his midwifery in an institution where sound methods of conservative midwifery are in the air of the place (I speak of the place I know best—the General Lying-in Hospital, York Road). Here he would see the midwife's part in midwifery clearly defined and understood. He would learn to appreciate and trust her. He would learn also the limitations of her teaching and knowledge, and when, where, and how to take over control of a case himself. In this connexion it is time to correct the idea that a nurse has special aptitude and training for, for example, the feeding of infants. The feeding of normal infants and the right principles of feeding and managing difficult infants should be even more the business of the medical student than of the midwife. It is certainly not suggested by one's experience of teaching that many individuals in either branch of midwifery regard knowledge of that department of midwifery as of enough importance.

Conclusions.

It seems to me, therefore, that on all grounds, practical and economical, and in the interests of good feeling, the teaching of midwives and doctors should be drawn together and not separated, and that the only practical way of doing

this is by extending and improving the existing lying-in hospitals in the way I have outlined. Any other course involves maiming these valuable institutions for their present function, without doing the education of medical students in midwifery any proportionate service.

I am aware that any article dealing with midwifery training is liable to produce a storm of vituperation from all quarters. This at least shows that someone has read it, though not necessarily that he has understood it. I can only hope that this article will be no exception, as that will show that it has caused someone to think about these problems a bit more.

Since writing the above I have glanced at Mr. Comyns Berkeley's Lloyd Roberts Memorial Lecture, and see that he has incorporated therein some of the objections I raised to his plan in conversation with him. I do not see, however, that he has seriously modified it for the better, and I believe my plan meets most of the objections to his; and although at first sight it appears more complicated, it is really the only practicable plan that at present exists for dealing with this great problem.

Scotland.

Vital Statistics of Edinburgh.

A REPORT to the Public Health Subcommittee of Edinburgh Town Council by Dr. W. Robertson, medical officer of health for the city, was presented at a meeting on January 21st, and showed that the death rate from all causes for the city during the year had been 15.1 per 1,000, as against 13.7 in 1928. This increase had been due to an epidemic of influenza, and, in addition, a considerable number of deaths had been caused by pneumonia. The epidemic disease rate for 1929 had, however, been lower than that of 1928, the figures being respectively 0.3 and 0.6 per 1,000 of the population. A striking fact was that no death from measles had been recorded in the city since July, 1928. Infantile mortality had been greater than in 1928, the figures for 1929 and 1928 being respectively 80 and 75 per 1,000 of the population. New housing schemes were gradually changing the numbers of inhabitants in various districts of the city, with an increase of the suburban districts, and a decrease in the more crowded districts as, for example, in St. Leonard's ward, where there was a decrease of 1,850, and in Leith a decrease of 1,104 in the population.

Edinburgh Royal Infirmary Extension Scheme.

The committee appointed by the Court of Contributors of the Edinburgh Royal Infirmary to consider the annual report by the managers of the institution, has issued its statement; the various items dealing with the numbers of patients and with the satisfactory financial situation, were recorded in the *Journal* of January 18th (p. 125). It is noted that a definite scheme for the utilization of George Watson's College grounds, adjoining the Infirmary, has now been generally approved by the managers, who propose to build upon this ground an up-to-date maternity and gynaecological department, and a nurses' home. These buildings are urgently required, the first to replace the Royal Maternity and Simpson Memorial Hospital, which will then become part of the Infirmary, although retaining its distinctive name, and the second to provide adequate accommodation for the large staff of nurses which in future will be required in the institution. This extension will materially increase the number of beds available in the Infirmary for general patients, and more particularly for surgical cases. The plans show two pavilions on the new ground in line with the four existing pavilions facing south, each giving accommodation for 120 patients. To the north, the new nurses' home will be capable of accommodating 300 nurses, with the necessary recreation, sitting, and other rooms. To meet the expenditure that will be required, it is proposed to launch an appeal for funds in the spring of the present year, when the public will be invited to subscribe £300,000. The estimated cost of the ground will be £90,000, and of the new buildings approximately £200,000. In addition to this the recon-

struction of Beechmount, Murrayfield, to adapt it for a radium institute with accommodation for thirty-six patients, will probably cost about £40,000, which is to be defrayed from the reserve funds of the Infirmary.

Glasgow Maternity and Women's Hospital.

The third annual medical report of the Glasgow Maternity and Women's Hospital deals with the year 1928, during which 114 beds were in use, 25 being reserved entirely for the ante-natal department. Dr. J. N. Cruickshank, the registrar of the hospital, explains, however, that there is nearly always a considerable number of extra beds in use, so that the average number of patients in residence daily is well above this figure, and, by arrangement with the Glasgow Parish Council, additional extra beds in Stobhill Hospital are available. This co-operation with the parish council has enabled the Maternity Hospital to continue its policy of not refusing treatment to any woman in labour, without increasing the already serious overcrowding of the wards. In presenting the statistical matter of the report Dr. Cruickshank has followed as closely as possible the standard scheme suggested by the committee appointed by the Royal Society of Medicine for unification of the clinical reports of maternity hospitals, but the simple division of cases into "booked cases" and "emergencies," which the committee suggested, has not been found capable of full application. The cases admitted to the wards have been placed in three categories: those which had been under ante-natal supervision for a sufficient length of time for the diagnosis and treatment of any abnormality present (1,612); patients sent in as emergency cases by outside doctors or midwives, or by doctors, nurses, or students working in the outdoor department (1,496); and patients applying for admission who had not been under previous ante-natal supervision (833). The last class was made up for the most part of women who applied for admission at the onset of labour without having been seen by a doctor or midwife. Thus, of the total of 3,941 patients treated in the wards of the hospital, 40.8 per cent. had been under ante-natal supervision of some kind, 38.9 per cent. came in as emergency cases, and 21.1 per cent. were admitted without having been under previous supervision. The total number of cases treated in the wards of the ante-natal department was 1,345; some patients were admitted directly to the obstetrical department from the outdoor (ante-natal) dispensary. With this ante-natal dispensary are combined a post-natal dispensary and an infant consultation (child welfare) centre; the total attendances at this group of institutions during 1928 numbered 16,830. The hospital is also responsible for a great deal of obstetrical work in the homes of the patients, and from this source emergency cases are admitted to the wards.

Care of the Mentally Unfit.

At a meeting of the Edinburgh District Board of Control, on January 20th, Colonel A. Young, the chairman, presented a statement dealing with the past work of the Board, and the plans for the future care of lunatics and mental defectives under the new administration. He said that the great achievement of the Board, the construction of the mental hospital known as Bangour Village, was recognized by mental experts throughout the world as an outstanding model of what such an institution should be; this would stand as a monument to the work of the Board. The Board was at present engaged in the construction of a great complementary institution at Gogarburn. When completed by the successors of the Board, it would form a home for patients of all ages, and of every possible variety of character and disposition, through grades of human intelligence up to the level at which mental defect could with difficulty be detected. There would be an immense opportunity for those concerned in training mental defectives to grade them according to their diverse capacities. Each patient would be kept interested so far as the individual ability permitted, and in order to awaken and cultivate latent powers, every variety of object lesson and of handicraft as well as games and amusements would be provided. Education as comprised in books did not stand very high in such an institution, where many