A PLEA FOR A UNIVERSAL STANDARD IN THE OBSERVATION OF THE MORBIDITY OF CHILDBED.*

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IT is one of the notable signs of a real advance in obstetrics that nowadays, for purposes of statistics, and consequently for the improvement of treatment, attention is given, not merely to the rate of mortality incident upon childbirth—always a criterion of some value—but also, and more particularly, to those earlier and often slighter changes, indicated by a rising temperature and a quickening pulse, which have been grouped under the heading of morbidity. It must be admitted by all that it is the closer and more general attention to this morbidity of the childbed that has led to an earlier recognition and a more efficient treatment of those septic puerperal complications which so frequently cripple, and at times kill, the unfortunate patient. The question has therefore an important educational value.

No one who has studied the periodical reports of "maternity" hospitals in any country can rest satisfied with the present methods of observing and recording the morbidity of childbed, or with the varying standards created by individual observers, which greatly reduce the value of otherwise careful and reliable records.

For comparison of statistics, either of individuals or of hospitals, the present state of matters cannot be said to be satisfactory. One observer takes the temperature of his patients in the mouth, another in the axilla, a third in the rectum; one hospital records its temperatures at different hours or intervals of the day from another; one authority disregards the temperature of the first twenty-four hours, another includes it. The correctness of the thermometer also varies, and there is need for strict regulations as to all the precautions to be observed both by doctors and by nurses in the actual method of taking the temperature. The question of the pulse is disregarded by some and is considered very important by others, and by the latter the pulse-rate is always taken into account in estimating their morbidity. Again, abortions are included by some, excluded by others; while some hold that all deaths should be included, others that only deaths accompanied by some degree of fever should count.

All these varying conditions and methods lead us to the most difficult question of all—the unfortunate variation of the standards that have been adopted by different individuals, hospitals, or associations. To illustrate this important point I shall take four familiar standards of morbidity—the so-called Continental standard of 38° C. or 100.4° F., and the standards of the British Medical Association, the Rotunda Hospital, Dublin, and Queen Charlotte's Hospital, London.

Table of Cases taken by one Observer and Tested by these Standards.

	Primi-para.	Multi-para.	Total.
1. Queen Charlotte's Hospital*	37	7	44
2. Continental, 100.4° F. (38° C.)	26	6	32
3. Rotunda Hospital, Dublin, 99° F. (37.2° C.)† ...	14	2	16
4. British Medical Association, 100° F. (37.8° C.)‡	11	1	12

* Every temperature above 100° F. (37.8° C.) is morbid.

† When temperature after first 24 hours exceeds 99° F. and pulse 90 on three consecutive occasions, the case is morbid. Include abortions, but exclude death without fever.

‡ If the temperature reaches 100° F. on any two occasions between the second and eighth day the case is morbid. Include all deaths, but exclude abortions.

CONCLUSIONS.

Surely the foregoing considerations and these figures that so markedly demonstrate the disparity of the four standards warrant the following conclusions:

1. It is desirable to have a uniform standard for the scientific records of morbidity in the puerperium.

* Extract from a paper read at the International Obstetrical and Gynaecological Congress, Berlin, September, 1912.

2. For this only thermometers of ascertained correctness should be used.

3. The observation should always be made in one place, preferably the mouth, and extend over a fixed time.

4. The temperature should be taken at stated intervals and at the same time of the day, and the first day should be included.

5. The record should include all abortions and also all deaths with a previous morbidity.

6. Both temperature and pulse should be taken, and the lower limit in each should be fixed by resolution of the International Congress for Obstetrics and Gynaecology, and thus become a recognized, universal, uniform standard of morbidity for use in all scientific communications.

SOME REMARKS, WITH STATISTICS, ON THE TREATMENT OF 1,305 SCHOOL CHILDREN (LONDON COUNTY COUNCIL)

AT THE ROYAL LONDON OPHTHALMIC HOSPITAL
(MOORFIELDS).

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IN presenting this report on 1,305 children who passed through my hands in the special department for the treatment of London County Council school children during the nineteen months from May 27th, 1910, to December 31st, 1911, at the Royal London Ophthalmic Hospital, "Moorfields," I am conscious that the number of cases dealt with is too small to enable one to make any dogmatic assertions, but I am hopeful that, at any rate, the details may be of some interest to those concerned with the welfare of the children. The bringing together of such large numbers of children for treatment gives one most valuable opportunities for studying the wider problems of refractive errors, which errors represent the major portion of the eye defects in children—for example, the factors at work in their causation and development; the effect of environment, nutrition, feeding, study, age, heredity, etc., particularly in regard to myopia, its beginning and progress.

I propose first to deal with a few aspects of medical inspection as they occur to one engaged in treatment. I may remind the reader that, when speaking of inspection, I am only referring to the inspection for defects of vision.

First, in regard to the periods of the child's school life in which inspection takes place, these periods, so far as the London County Council scheme is concerned, are the following:

- Entrants.
- Age 8 to 9 group.
- Leavers, aged 13 to 14.
- Those cases specially referred by the school teachers.

It is group (b) that I am more particularly concerned with, and I feel strongly that instead of inspecting the children of about 8 or 9 years old, it would be of more value if they were re-examined when 6 or 7 years old, or as soon as the child is able to read the alphabet, because, although, no doubt, a few at the time of entrance inspection—namely, at 5 years old—are able to read the test types, yet the larger number cannot, and are therefore classed as "illiterates," and unless they have some obvious defect, they are passed over until the next inspection period, which, as I have said, takes place at 8 or 9 years of age. To digress a little, I might, perhaps, mention that, as a matter of fact, many children who do not know their alphabet or numerals, can be got to read some form of "illiterate" type. Personally, I am in favour of, and use the E type, which consists of a series of the letter E placed in various positions—for example, E ㄢ ㄣ ㄤ, each line or row of letters being made to correspond in size to those of the standard Snellen type. The child is given a metal letter E, painted black and mounted on a handle; after a little explanation and encouragement the child is soon got to place the mounted E, which is held in the hand, in a position corresponding to that of any letter E pointed out by the examiner on the test card. However, there is no denying the fact that this test takes some