THE GENERAL PRACTITIONER AND THE ANTE-NATAL CLINICS OF LOCAL AUTHORITIES

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In advocating, as I do, that ante-natal care should be directed in and from the clinic, I wish it to be clearly understood that this procedure applies only to "insured persons" and to those who would become insured persons under a National Maternity Service based on the Insurance Principles. The word "insured" is used in this sense throughout. I assume that ante-natal supervision of non-insured persons will continue to be carried on in the patient's home and the doctor's consulting room.

It is common knowledge how public health authorities by various enactments, more especially the Notification of Births (Extension) Act of 1915 and the Local Government Act of 1929, had allocated to them ever-increasing responsibilities in the domain of obstetrics. In 1914 the Local Government Board offered grants to local authorities for the provision of ante-natal clinics. The Departmental Committee on Maternal Mortality and Morbidity, in its Final Report (p. 33), states: "Some 860 such clinics are provided by local authorities." In Scotland the number is smaller—182 (December, 1931). In addition, there are numbers of ante-natal clinics (England, 190) associated with voluntary hospitals and associations, all more or less co-ordinated with the ante-natal work of the local authorities, many being partially or completely subsidized by them.

There is, then, an extended network of clinics in England and Wales and in Scotland. The clinics of local authorities, with their ancillary services, have been an enormous boon to large numbers of women in many directions, which need not be detailed. Unfortunately, however, there is another side to the picture. Ante-natal clinics have had the effect of dissociating the patient and the general practitioner. Admittedly, large numbers of pregnant women who attend the ante-natal clinic have no family doctor. The "clinic habit," however, is extending, so that many who would employ a doctor are receiving free advice in the clinic; particularly is this the case at the present time, when there is so much unemployment.

This development has had the effect of arousing a certain amount of opposition among general practitioners, more particularly in large urban areas very much industrialized. In smaller urban and rural areas the feeling may be less pronounced or entirely absent where local practitioners are employed to carry out the work. The position at present would appear to be that health authorities (central and local) are not quite frank enough in indicating their policy and objectives, while general practitioners are not accommodating and willing to adapt their methods of practice to suit modern developments.

The ideal place for supervision of insured persons is the ante-natal clinic of local or municipal authorities on the outdoor clinic of maternity hospitals (consultant clinics). There only can the bulk of patients be thoroughly examined; in and from there only can the work of all agencies concerned with maternal welfare be fully co-ordinated; there only can "health sheets" be satisfactorily preserved.

The manner in which the question of the ante-natal clinic is presented by the Departmental Committee in its interim and final reports is too indefinite. Take the following statement (Interim Report, para. 177):

"As to the relation of the doctor's duty in the matter of ante-natal care to the work of ante-natal clinics, the Committee is of opinion that it is a principle to be acted upon, wherever possible, that the person responsible for ante-natal supervision should be responsible for attendance during labour. They agree, however, that in order to avoid any hiatus in the important work which ante-natal clinics are now carrying out it is necessary that they may be continued, but they anticipate that as the service becomes fully developed the clinics will

lose to a great extent their character of routine clinics and be used more and more for consultations between general practitioner and specialist. Apart from their medical aspect, the clinics take an important place in the teaching of the midwife and the education of the mother, and their use is at present necessary in the practice of midwives who are unable to do ante-natal work of the required standard."

We take an entirely different view: we visualize the ante-natal clinic under local authorities becoming ever more important, and feel certain this will be the development in the future. It is a little doubtful if the Committee or the individual members responsible for the insertion of this paragraph are quite sincere in the opinions expressed. Local authorities are extending existing buildings and erecting additional clinics, for the demand made by expectant mothers is ever-increasing and is compelling them to supply additional accommodation and service. The Departmental Committee appears to be satisfied with this development, to judge by a later statement in the Final Report anent the increase in numbers of clinics in England (pp. 32 and 33).

In the statement of the Departmental Committee here quoted the opinion is expressed that the clinic may "be used more and more for consultation between general practitioner and specialist." We entirely disagree with the suggestion. The place for consultation between specialist and practitioner is the ante-natal clinic of the hospital to which the specialist is attached, where he does his work and has a complete equipment for investigating obscure cases. In the Final Report (p. 33) is this statement:

"The establishment in one or two larger centres in the district of a consultant clinic staffed by specialists, to which patients could be referred from the ordinary clinic or by general practitioners, is a measure which has already proved its value to both patient and practitioner in some areas."

Here the committee is on sound ground. To attempt to destroy or lessen the function of the ordinary ante-natal clinic would be folly, and although this was suggested in the Interim Report (para. 177) I do not believe it was the considered opinion of the committee.

Medical practitioners, more particularly those engaged in general practice in urban areas, must present some concrete proposal indicating how far they are prepared to carry on the service of ante-natal clinics in co-operation with local authorities, otherwise such authorities must continue to appoint medical officers of the health service. This would ultimately mean that the ante-natal care of insured persons would pass out of the hands of general practitioners in industrial areas. The matter is most serious. General practitioners will drop out of the service in large industrial areas unless they are prepared to do ante-natal supervision in the clinics. They were given the opportunity some years ago of taking part in the campaign against tuberculosis. They could not be persuaded to co-operate fully with the public health authorities, with the result that this particular work has passed almost entirely into the hands of local health authorities. Matters will become still worse when a general medical service is established, for it undoubtedly will have its base in the welfare centre, which will then become the "medical welfare centre" for the particular area.

The clinics must win in the end: firstly, because in large cities they are in liaison with municipal hospitals; secondly, because the bulk of individuals in industrial areas are being slowly and quietly educated, and are coming to realize that the most convenient place for undergoing a medical examination and receiving medical advice and treatment is the clinic fully equipped for all the purposes it should serve. But not only is the clinic the natural medical centre, it is the natural centre of activity for all ancillary medical and social services concerned with maternal welfare.

It is profitless to talk generalities about co-operation between the different agencies. These agencies will not dovetail by accident; they must be carefully pieced together and adjusted in the welfare clinic. Their activities are restricted unless directed from the clinic.

Health authorities are well aware that unless medical practitioners agree to do the ante-natal supervision of their

insured patients in the clinic the entire ante-natal care of insured persons will fall into the lap of local authorities and their medical officers. I do not for a moment suggest that this would be a disaster; it is possible that it may be the ultimate development. On the other hand, I wish general practitioners to be given every chance to co-operate. Should they do so completely and efficiently this would be a better arrangement.

Exception must be taken to the manner in which certain local authorities are developing their maternity services.

The following advertisement appeared in the *Glasgow Herald* in February of this year:

"BURGH OF . . . AND . . . (SCOTLAND)

"Applications are invited by the Town Council of the Burgh of . . . and . . . from duly qualified Medical Practitioners (Male or Female) for the position of Resident Medical Officer, Maternity and Child Welfare Department. Candidates must have at least three years' post-graduate experience of medical practice, and possess the D.P.H. or similar qualification. Special experience in Obstetrics or Gynaecology and of Diseases of Children and of Maternity and Child Welfare Work is essential.

"Duties include obstetrical work in a maternity hospital, the conducting of ante-natal clinics and child welfare consultations.

"Salary £350 per annum, rising by £25 annually to £450, with board and residence in the maternity hospital."

It will be observed, according to the advertisement, that obstetrical training is not essential, but that a D.P.H. is essential. Surely for appointments of this nature it is of primary importance that the medical officer appointed should have a wide training in obstetrics, and of comparatively little consequence that he should have a D.P.H. Young graduates well trained in obstetrics, who ultimately intend to take up obstetrics and gynaecology as a specialty, are anxious to secure such appointments, but they cannot possibly give up the time necessary to take a D.P.H. The salary offered is quite substantial, and would be willingly accepted as adequate remuneration by young graduates well qualified in obstetrics. No progress in improving the maternity service of the country can result if local authorities pursue the policy here indicated.

The Departmental Committee and all other *ad hoc* committees who have reported on maternal mortality have definitely expressed the opinion that the "person responsible for ante-natal supervision should be responsible for attendance during labour." Many medical officers of ante-natal clinics under local authorities never take part in intra-natal supervision. It is the general practitioner who is called out to assist the midwife should a difficulty arise. *It is obvious that either medical practitioners should be associated with the clinics or the officers of local authorities should go to the assistance of midwives.* A most unsatisfactory position is being created in many localities, which cannot possibly be to the advantage of pregnant and parturient women. The country will not wake up one morning and find itself—"in possession of a national maternity service without knowing quite how we got it," as Watts Eden¹ suggested in a recent lecture delivered to the Cardiff Division of the British Medical Association. The country will only secure a satisfactory midwifery service when all the agents concerned have their individual duties defined and their activities centred in maternity hospitals and ante-natal clinics.

Various attempts have been made in recent years to persuade general practitioners to co-operate with local authorities and carry out ante-natal care in and from the clinic. In Hampshire Dr. H. Leslie Cronk,² county M.O.H., has introduced a service very closely resembling the one here suggested. The scheme as outlined provides that practitioners duly qualified for the post (qualifications are defined) will serve as medical officer in rotation normally for twelve months at a time. The period of duty will terminate on December 31st. Unless otherwise decided by the practitioners of the area, the order in which the service will be given will be determined alphabetically. Any general practitioner appointed will be expected to attend punctually at the time and place appointed, and to make such arrangements that his private work will not interfere with his obligation to the county council. The fee payable to a general practitioner for each session of not more than two hours will be one and a half guineas.

The service established in Cumberland by Dr. F. H. Morison,³ M.O.H. for the county, is radically different in this respect, that the ante-natal care is not necessarily carried out in the clinic. The arrangements for provision of additional midwives, early examination of patients by doctors, routine supervision by midwives, accouchement outfit, are all in accordance with modern ideas. It would appear that this arrangement is probably more suitable for certain rural areas. In Burnley a scheme has been initiated where the practitioners who wish to do ante-natal work do it in and from the clinics of the local authorities. This, I maintain, is the best arrangement in urban areas, more especially in densely populated industrial centres.

W. H. F. Oxley⁴ refers to the matter, and regrets that the scheme in Hampshire provides for attendance at the clinic, and that no provision is made for attendance at the doctor's surgery. Later in his paper he states in referring to the clinics that they are to be staffed by midwives and general practitioners. Now, *How does the East London Hospital secure such wonderful results?* The excellent results are obtained because patients attend the clinic of the hospital and are carefully supervised there by midwives. If they do not or cannot attend they are visited in their homes, and, if any abnormality arises, Dr. Oxley and his staff are consulted; if the complication of pregnancy or labour is deemed serious the patient is transferred to the hospital. *This is precisely the service I am advocating for the country.*

Dr. Oxley⁵ returns to this subject in a later communication: "Many local authorities and medical officers of health, however, appear to take an exaggerated view of the usefulness of publicly provided clinics, and are blind to their limitations and disadvantages." Of course there are disadvantages, but the advantages of the clinic in respect to insured persons far outweigh the disadvantages in large centres of population.

MIDWIVES AND ANTE-NATAL CLINICS

The remarks made here deal only with the relation of midwives to ante-natal clinics.

The most authoritative pronouncement regarding the place of the midwife in a maternity service of this country is contained in the Report of the Departmental Committee on the Training and Employment of Midwives (1929). In the service outlined the midwife is to undertake the routine ante-natal, intra-natal, and post-natal supervision of patients entrusted to her care; or, as the committee stated (para. 9):

"The midwife as the person responsible in the majority of cases for the care of the mother throughout pregnancy, confinement, and the puerperal period, is the one upon whom the main burden would rest. In all such cases there should be available the services of a doctor, with certain well-defined duties towards the mother, to whom the midwife should be able at all times to look for assistance when she is faced with difficulties beyond her ordinary competence and skill, and an obstetric specialist who would be called in by the doctor to deal with exceptional emergencies."

This policy has the support of the British Medical Association and the imprimatur of the Departmental Committee on Maternal Mortality and Morbidity (Final Report, p. 34).

Prima facie this arrangement is simple and rational, because the essence of ante-natal care is keeping a constant look out for the slightest disorder. This meticulous attention to, and supervision of, pregnant women is a type of work peculiarly suited to intelligent and highly trained midwives. As much of it is of a non-medical character, midwives under supervision are better qualified than doctors for routine ante-natal care. To put it very simply, the principle should be that midwives "mother" their patients during pregnancy.

It must be clearly understood, however, that this is throwing an enormous responsibility upon midwives. That the policy is safe if conditions are satisfactory is proved by the results secured by the Netherlands and by certain services in this country—for example, the General Lying-in Hospital, York Road, and the East End Maternity

Hospital, London, in both of which institutions the routine work (domiciliary and institutional) is conducted by midwives in training under supervision. What is necessary for the country generally is to organize the midwives' service on a similar basis, with possibly not quite so much elaboration as pertains in Holland.

If midwives are to be made responsible for routine ante-natal and intra-natal care, they must be: (1) more adequately trained; (2) under the jurisdiction of some authority, and the natural authority is the local authority. Special conditions should be laid down for midwives desiring to practise on their own account.

The reason for attaching so much importance to associating the midwife's work with the ante-natal clinic is that all her work would be under supervision. She would see her patients there when they can visit the clinic; her obstetric outfit would be kept in the clinic; and the case sheets or records of the patient's health would be preserved in the clinic. She would be the patient's health visitor throughout pregnancy. Should it be necessary for the patient's doctor to see the patient she would arrange accordingly. In the event of a patient having to go to a hospital she would accompany her there. By this arrangement the standard of her work would be kept at such a high level that it would be hardly necessary for her to take revision courses.

I was particularly pleased to notice a statement recently made by Dame Janet Campbell¹ to the following effect: "But there is a growing opinion that she would do her work better and under more comfortable conditions if brought definitely within a municipal or nursing scheme, as, indeed, is already the case in county districts." This is a considerable step forward. The next and final step is to associate the midwives with the ante-natal clinic.

ORGANIZATION AND STAFFING OF ANTE-NATAL CLINICS

The organization and staffing of welfare centres is fully outlined in "A National Maternity Service"² (paras. 44 to 51, and 64 to 76) which the writer proposed.

It is there suggested:

1. They are to be the centres for routine ante-natal care.
2. Each is to be in liaison with a particular maternity institution.
3. The routine ante-natal care by midwives is to be carried on in and from these clinics.
4. The ante-natal care with which the medical practitioner is more specially concerned is to be undertaken in and from the clinic. The final examination of the patient (month after delivery) is to be carried out in the clinic, and the final notes on her condition inserted in her case sheet, which should be filed in the ante-natal clinic.
5. The domiciliary service for women in labour is to be directed from the clinic where the midwives, who will be doing the bulk of this particular work, will keep their obstetric outfit and have it duly kept in order, as is done in the domiciliary services of all maternity institutions.
6. Accouchement outfits for patients may, if this is the most suitable arrangement for the locality, be stored and distributed from the clinic.
7. The case records of all patients are to be preserved and filed in the clinic.
8. The services of health visitors, home helps, and other social agencies are to be directed from the clinic.

With this arrangement the whole maternity service is brought into alignment—the institutions for patients requiring indoor treatment, ante-natal clinics of these institutions for ordinary work and in large cities and towns for *consultative purposes*, the welfare clinics for the ordinary supervision of expectant mothers, the domiciliary services associated with these clinics for the supervision of women in labour. The economic advantages of this arrangement are obvious.

REFERENCES

- ¹ *British Medical Journal*, March 11th, 1933, p. 400.
- ² *Medical Officer*, November 1st, 1930, p. 195.
- ³ *British Medical Journal*, October 18th, 1930, p. 649.
- ⁴ *Ibid.*, January 3rd, 1931, p. 6.
- ⁵ *Ibid.*, January 14th, 1933, p. 77.
- ⁶ *Ibid.*, November 26th, 1932, p. 962.
- ⁷ *Journ. Roy. San. Inst.*, 1931, lii, No. 4; *Lancet*, August 15th, 1931, p. 367.

Ireland

Regius Chair of Surgery

Sir Arthur Ball, Bt., has been appointed to the regius professorship in surgery at Trinity College, Dublin, in succession to the late Sir William Taylor. The new professor is senior surgeon to Sir Patrick Dun's Hospital, and examiner in surgery at the Royal College of Surgeons in Ireland. He is a grandson of Robert Ball, LL.D. (1802-57), the Dublin naturalist; a nephew of Sir Robert Ball, F.R.S. (1840-1913), the astronomer; and the eldest son of Sir Charles Bent Ball (1851-1916), honorary surgeon to the King in Ireland, who for many years occupied the chair of surgery to which Sir Arthur now succeeds.

Medical Registration Council

At the May session of the Medical Registration Council, held in the office of the Council, 35, Upper Fitzwilliam Street, Dublin, there were present: the president, Dr. Denis J. Coffey, Dr. James N. Meenan, Dr. Henry F. Moore, Dr. Stephen Shea, Dr. A. Francis Dixon, Dr. Edward Magennis, Mr. R. Atkinson Stoney, Dr. T. Gillman Moorhead, Dr. Robert J. Rowlette, and Mr. William Doolin. The registrar, Miss Hayes, was in attendance. Among the business dealt with was the appointment of Dr. Henry F. Moore to be a member of the Therapeutic Substances Advisory Committee, representing the Medical Registration Council, and the adoption of new penal regulations under Sections 28, 29, and 30 of the Medical Practitioners Act, 1927. The registrar stated that the reports on the recent visitations to the final medical examinations had been sent to the various qualifying bodies.

Federation of Hospitals

At the Charter Day dinner of the Royal College of Surgeons in Ireland the president, Mr. Frank Crawley, expressed his firm belief that the days of the voluntary hospitals were over, and referred to a statement made recently by Sir Henry Brackenbury, Chairman of Council of the British Medical Association, to the effect that hospitals were becoming less and less a provision by charitable people for the care of those who could not pay anything, and more and more a general provision by the public on a self-supporting basis for members of that public who required treatment. Mr. Crawley recalled that he had already drawn attention to "those prophetic words"; he was sure there would be, as there was then, the criticism: "And the greatest of these is charity." To that criticism he would like to point out that charity did not merely mean sending a subscription to the hospitals; another meaning of the word charity was love, and in that was included the idea of personal service. If the charitably inclined felt that they could not give their own service, perhaps they could pay those less endowed with the world's goods to do the service for them. The contributions of the charitable in the country would not be sufficient to keep the hospitals properly equipped and with a sufficient number of beds for the very poor, who formed a large proportion of the patients in all hospitals. Notwithstanding all that had been heard and read of patients being refused admission to hospitals, he ventured to say that in no single instance was the refusal for the reason that the patient could not pay. Referring to the new Charitable Hospitals Bill, Mr. Crawley said that this was a most important Bill, the main idea of which was correct. He believed that it was wrong to allow in Ireland a number of small hospitals, each trying to be in miniature a complete hospital, having every possible medical specialty provided for in its building, and having on its