BRITISH MEDICAL JOURNAL

LONDON: SATURDAY, AUGUST 4th, 1934

ARE WE SATISFIED WITH THE RESULTS OF ANTE-NATAL CARE?*

BY

JOHN S. FAIRBAIRN, M.A., B.M., B.Ch.Oxon, F.R.C.P., F.R.C.S., P.C.O.G.

CONSULTING OBSTETRIC PHYSICIAN, ST. THOMAS'S AND GENERAL LYING-IN HOSPITALS

The question forming the subject of this discussion comes at an opportune moment, although it can admit of a negative answer only, as finality in progress is unthinkable. At the same time we have no grounds for complacency. For twenty years or more ante-natal care has been vaunted as the sovereign remedy for the static maternal death rate, which, however, obstinately refuses to respond to treatment. Hence, I take it, our object is to review our ante-natal work and to see where its weaknesses lie, and the task I have set myself is to restate its aims, the attitude of mind in which it should be approached, and the principles underlying its practice. Clinical details I leave to my obstetrical colleague.

Midwifery a Branch of Preventive Medicine

The ante-natal clinic deserves much of the credit for the impulse leading up to a general recognition of "midwifery as a branch of preventive medicine," a slogan that had a wide vogue for a time, although it is clear that all it implied was not understood and certainly not acted upon. My interpretation of preventive medicine translated into clinical practice is that the promotion of health and normal working in all systems of the body becomes the primary objective. In midwifery, where the reproductive function in women is our charge, our first and chief duty is to learn what can be done by constructive physiology—that is, the adoption of measures tending to promote normal function throughout the processes of reproduction. After this comes the "preventive" part, strictly speaking, the removal or correction of possible causes of interference with physiological action. Lastly comes the watch for early evidence of disordered function and the effort to restore the normal before more serious or permanent trouble arises—for example, the testing of urine to discover albuminuria and the conditions underlying it.

Thus in successive stages we pass from constructive physiology through prevention to what may be termed, by antithesis, "destructive pathology." My point is that the first and constructive stage has not been fully understood and accepted as the primary purpose of the supervision of the expectant mother; often the two later stages are alone considered. About a year ago I noticed a letter in the *Lancet*¹ in which this aspect was put so clearly that I venture to quote the words most appropriate to ante-natal clinics, for the letter was not prompted by them, but by a proposal for the periodic examination of women to discover the early stages of uterine cancer before symptoms arose. The writer of the letter, in setting out his objections to that suggestion, said:

"Our own generation, however, seems to have more fear of disease than love of health; we ourselves are not free from

the belief that it is our sole function to search out abnormalities, to declare them and to correct them if we can, and we are still far from the day when the reproach of having imagined a pathological condition will be esteemed as great or greater than the reproach of having overlooked one."

This quotation sums up the incorrect perspective in which much of our ante-natal work is viewed. The search for trouble is too much in the foreground, and constructive hygiene too far in the background. Hunting for signs of the abnormal results in the most being made of minor deviations from the mean, and often without proper consideration being given to the reserve power of mother nature. Here will be a misfit that must be beyond the natural powers, or there a cardiac or other medical complication that must prove fatal unless Caesarean section is performed or abortion or premature labour induced. It is generally accepted^{2,3} that intervention for hypothetical trouble has been grossly overdone, and a material proportion must be ascribed to misunderstanding the purpose of, and to misdirected zeal in, the conduct of ante-natal supervision.

More than lip-service is needed before midwifery is, in fact, "a branch of preventive medicine." The whole practice of midwifery, and particularly ante-natal work, must live up to the principle that its primary aim is the attainment of normal function. Once this ideal permeates completely the ante-natal period it will leaven the whole.

Study of the Individual

The next point I will emphasize is the importance of full consideration being given to the individual woman, mind as well as body, her circumstances, and her reactions to them. She is too frequently regarded as if she were a cow, and had no thought of what pregnancy, labour, and the rearing of her progeny involved. There is too much veterinary practice in obstetrics as well as in general medicine and surgery, and, in these days particularly, when there is much more talk in the vulgar tongue on problems of sex and reproduction, the reaction of the expectant mother to pregnancy and all it means to her is given too scant attention. In the textbooks there is a learned discussion of her biochemical reactions, normal and abnormal, but little or nothing of her mental responses. She may be distracted by an unwelcome pregnancy and desire its interruption, or she may be overjoyed that a long-hoped-for pregnancy has come but obsessed with fears of its premature ending or of disaster to the foetus. Or again, she may be full of dread of what is before her, or terrified by stories of what she has heard from others; or she may, like the cow, have given no thought and worried not at all as to what is in front of her. But all women should not be treated alike, as if they were cows and without imagination.

Our ante-natal supervision has not as yet enabled us to predict a natural delivery for a healthy well-formed

* Read in opening a discussion at a joint meeting of the Sections of Obstetrics and Gynaecology and Public Health at the Annual Meeting of the British Medical Association, Bournemouth, 1934.

woman with a normal presentation and position. She may take a day or more, and in the end be delivered artificially. This result may be accepted as next door to a natural delivery, but surely we should not be satisfied with second best, but should seek some means of improving the final expulsive efforts whereby the frequent resort to artificial methods may be avoided. This problem has scarcely entered into the philosophy of ante-natal care, although it is now generally agreed that the largest factor in the failure to complete expulsion is the emotional effects of anxiety and fear and the early fatigue that follows in their train. More attention is now being paid to this aspect of ante-natal work, but by general practitioners rather than by professed obstetric specialists, and several books⁴ and papers have recently appeared stressing the importance of the psychic factor during pregnancy and labour.

In the individualization of the pregnant woman must be included also the social and educational work that forms an essential portion of the ante-natal care in all classes of the community, and calls for modification to suit the character and special circumstances of each patient. It is well done in the public ante-natal clinics, and in those hospitals with a social service department, in both of which there are officers specially detailed for the duty of home visiting and inquiry; but it is liable to be overlooked in private practice⁶ and in smaller institutions.

Thoroughness and Continued Observation

The next point to be emphasized is that the supervision of the pregnant woman must be thorough and continued. The fault does not seem to me to lie so much in the medical and obstetrical examination as in the less obvious aspects already referred to, and in the failure to resort to continued observation in hospital or nursing home of cases showing slight or early signs of departure from the normal. The gravity and meaning of slight losses of blood during pregnancy, of vomiting that does not yield to simple remedies, of minor degrees of albuminuria or rise of blood pressure, and of many general diseases complicating pregnancy cannot be accurately estimated unless the woman is under medical observation and watched by competent nurses. Occasional visits to a clinic or medical attendant do not afford a satisfactory basis for a prognosis or judgement on the effect of treatment. But either from lack of facilities or failure to recognize the need for closer observation many disorders in an early stage are allowed to become serious before correct treatment is begun.

Unity in Purpose and Method

Reference to those sadly overworked words "co-ordination" and "co-operation" cannot be avoided, because ante-natal care calls for varied forms of service from various types of worker and for close contact between all of them, and unity in purpose and method are largely contributory to its effectiveness. Ante-natal supervision is so integrated with the rest of midwifery practice that it cannot be separated off without the efficiency of both the part and the whole suffering greatly. Its segregation in the public ante-natal clinics has been open to obvious criticism on this score, though the policy was more or less forced on the local health authorities by the Act of 1918. The result has been that the country has never received a proper return for the money expended on these clinics, a fact which seems to have struck the officials in Whitehall, judging by their memoranda advocating a co-operation so effective as to overcome all drawbacks to an ante-natal supervision exercised by those who have no concern with the mother during labour and lying-in.

In spite of team work and a certain degree of uniformity in practice, our large maternity hospitals are not free from this failing: there is one member of the staff for the pre-

natal, another for the intra-natal, possibly a third for the post-natal care of the mother, and certainly another for the mother and infant in the infant welfare clinic. Reports between these different members of the staff cannot wholly compensate for the personal touch, and the influence that goes with it, when the woman is throughout under the same charge. The effort should be made to maintain responsibility for each patient in the same hands at least from pregnancy until mother and infant are passed to the infant clinic.

For these reasons the family practitioner is the ideal supervisor of the mother and her infant throughout reproduction, but, if he is to fulfil his part adequately, he must have assistance from a midwife, working under his direction to undertake the observational, educational, and mothercraft services given by health visitors, social workers, and other officers in hospitals and public clinics. The British Medical Association scheme to delegate this part of the work for insured patients to the public clinics does not appeal to me because of the division of responsibility and the loss of personal influence thereby entailed.

In conclusion, I trust the emphasis I have laid on the attainment of the physiological as our primary aim will not be taken as lessening the need for observing signs of departure from the normal. I have tried only to correct the perspective.

REFERENCES

- ¹ Batten, L. W.: *Lancet*, 1933, i, 441.
- ² Browne, F. J.: *Ibid.*, 1932, ii, 2.
- ³ Wrigley, A. J.: *British Medical Journal*, 1934, i, 891.
- ⁴ Pink, C. V.: *The Ideal Management of Pregnancy*, London, 1930.
- ⁵ Read, G. Dick: *Natural Childbirth*, London, 1933.
- ⁶ Fairbairn, J. S.: *Practitioner*, 1932, cxxix, No. 3, 313.

ARE WE SATISFIED WITH THE RESULTS OF ANTE-NATAL CARE?*

BY

F. J. BROWNE, M.D. ABERD., D.Sc., F.R.C.S.ED.,
F.C.O.G.

PROFESSOR OF OBSTETRICS AND GYNAECOLOGY, UNIVERSITY OF
LONDON, AT UNIVERSITY COLLEGE HOSPITAL, LONDON

Dr. Fairbairn has referred to the influence of the emotions in pregnancy and childbirth, and we shall probably all agree that in our enthusiasm for the development of the preventive side of obstetrics we have occupied ourselves too exclusively with mechanistic conceptions of the physiology of labour and with mechanical measures for meeting the difficulties encountered. It is worthy of note, also, that the late Dr. Ballantyne, in his last address in 1923, in which he set out clearly the benefits that he expected would follow ante-natal care, put in the forefront "the removal of anxiety and dread from the minds of expectant, parturient, and puerperal patients, and the removal of much discomfort amounting in many cases to suffering."

It is a matter of some historical interest that Ballantyne was originally led to advocate ante-natal care, not for the sake of the mother at all, but in order that we might be enabled thereby to discover the causes of, and to prevent, monsters. This we can easily understand when we recall that his two volumes on *Ante-natal Pathology* had been published in 1904, and that all his work and interest up to that time had been concentrated upon foetal pathology. It was only much later that he came to see that other gains might follow, such as reduction of the maternal death rate and of the number of stillbirths and neo-natal deaths.

* Read in opening a discussion at a joint meeting of the Sections of Obstetrics and Gynaecology and Public Health at the Annual Meeting of the British Medical Association, Bournemouth, 1934.