THE PROBLEM OF THE MIDWIFERY SERVICES FROM THE STANDPOINT OF THE COUNTRY PRACTITIONER*

BY

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I have been asked to deal with the problem of midwifery practice as carried on by the country practitioner, one who lives at such a distance from hospital and from expert assistance that he has to rely on his own skill and resources and on the help of his fellow practitioners.

I have been doing midwifery in a semi-industrial area for the past thirty years, thirty miles from the nearest maternity hospital in Newcastle-on-Tyne. During this time I have had a considerable and varied experience of midwifery and its accompanying anxieties. I do not wish to waste time by being reminiscent, but I must mention the conditions of midwifery practice as I found them when I started. Handywomen flourished, and it was difficult to persuade patients to have the services of the district nurse. The objections raised were numerous and varied. Some patients thought that the district nurse required too many clean clothes and was too particular! Many mothers were conservative, and thought that what was good enough for them was good enough for their daughters. In my own area the era of the handywoman ceased because we refused to go to any case at which the nurse was not in attendance.

When I began in practice there were no consultative schemes, and one had to rely on one's own resources and on the help of local colleagues. The senior general practitioners of those days were all skilled obstetricians: they had to be if they were going to be successful doctors, and it was from them that we learnt our midwifery. There was no system of ante-natal supervision, and some tragedies would have been avoided if there had been. I recollect working with two of my seniors for five hours with a Bossi's dilator in a case of eclampsia and pulling an infant through a partially dilated cervix. It is a tribute to the hardihood of the Northerner that both mother and infant survived and are alive to-day. At the time the feat was considered remarkable; it was certainly hard work.

I think that the attitude of patients towards hospital treatment has undergone a marked if gradual change, and when such is suggested they express a willingness and confidence which used to be lacking. The Newcastle Maternity Hospital at that time had only fourteen beds and admitted no single women, so hospital treatment then was limited! I do not think that in my area the housing conditions have altered in the slightest so far as working-class property is concerned. In fact, owing to industrial depression, much of the latter has deteriorated. The sanitation is still the old earth closet, and the doors of the ashpits are frequently non-existent.

Midwifery Practice in Northumberland To-day

In North Northumberland we have not adopted the scheme of having an ante-natal centre. We have instead an arrangement which we consider a better one. Any practitioner who desires an opinion on a case can send his patient to consult a specialist at his consulting rooms in Newcastle. The county authority pays the consultant's fee, and the travelling expenses of the patient and one attendant if the circumstances warrant the latter payment. If the practitioner considers that it would be detrimental

for the patient to travel the consultation is arranged at her house. This scheme also includes expert assistance during labour and in puerperal conditions. The general practitioner has only to notify the medical officer of health of his desire for a second opinion, and give the reasons.

In my own practice I set apart an hour each week for ante-natal work. I find that this is appreciated by my patients. It is not fair to expect a woman in an advanced state of pregnancy to attend along with others, and the privacy thus ensured makes the arrangement a satisfactory one. I make a record at the first visit of the name and address of the patient, the date of the last menstrual period, when the baby is expected, and of such essential particulars as the position of the head, measurements, blood pressure, and the examination of the urine. The patients are asked to attend every fortnight.

Nursing

In North Northumberland, in spite of the inadequate fee, we have not allowed this work to pass out of our hands. Every pregnant woman has the advice and supervision of a doctor during pregnancy, labour, and the puerperium. She is not left solely to the care of a midwife, who, in my opinion, cannot be entrusted with the responsibility of deciding that a case is perfectly normal. A midwife may undertake a normal case under the supervision of a medical man, but there her duty should begin and end. A practitioner should be engaged for every case, and should have seen the patient and satisfied himself that it is a suitable one for the midwife to undertake. I am opposed to the system which allows a midwife to fill in a form and summon a doctor to a patient who may be a complete stranger to him.

In my opinion the low rate of payment for maternity work and the uncertainty of getting the modest fee agreed on discourage doctors from accepting cases. The system is wrong, and will persist until a more generous attitude is adopted by the general public and the health authorities towards this part of our professional work. In these days of industrial depression those of us who insist on seeing and superintending a case beforehand are frequently unpaid.

If local authorities supplied some expectant mothers with sterile dressings at the request of the doctor or midwife there would be less danger of infection. One of my patients died from tetanus, which was attributed to the dressings having been laid out to dry in a field. The catgut used was tested and proved sterile. A weak point in the present system is that the nurse attends all sorts of general cases, septic and otherwise. In many areas it is impossible to limit a nurse's activities to midwifery. There should be an arrangement whereby her attendance on septic cases at the same time as on confinements could be avoided, perhaps by a system of reliefs. In this connexion I can recall some years ago an instance of a handywoman who had had an attack of erysipelas and who infected the patient; the latter died of virulent puerperal sepsis, and the cycle was completed by the mother of the patient developing a severe erysipelas.

In Northumberland there is a scheme whereby the County Nursing Association supplies on request a nurse who stays with, and devotes her whole attention to, the care of a patient who is severely ill. She also attends to the domestic duties in the house—an important matter where the husband is a working man. Unfortunately it is not within the means of every family to pay for such attention, and this, I consider, is a question of considerable moment, because in severe illness the nurse gives a much more useful service than any midwife could do under the usual arrangement.

* Read in the Section of Obstetrics and Gynaecology at the Annual Meeting of the British Medical Association, Oxford, 1936.

Anaesthetics

Among the difficulties encountered in dealing with the abnormal case in the house of the patient, and one that has on occasion been a source of anxiety to me, is that of the administration of the anaesthetic. I have always used chloroform. It has the reputation of being safe in midwifery, and I believed this for many years until on one occasion I had, as most of us have had, an unpleasant experience. For many years I gave the anaesthetic and carried out the instrumental delivery myself. Since that time I have made it a rule to secure, if possible, the services of a colleague for the administration of the anaesthetic in any case of difficulty, and it is surprising how an anxious and difficult procedure becomes simplified if you are able to give your undivided attention to the task in hand. In my own area we now do this for each other, frequently without remuneration, and I think that the provision of such services would be an added safety for the patient.

I always apply forceps with the patient in the left lateral position. There is then less trouble with the anaesthetic, and the air passages do not get obstructed. I have not found that cases of disproportion between the size of the foetal head and the pelvis are common. I make it a rule that if the head is not engaged in the pelvis in a primipara by the last month she should have expert advice. We have no difficulty in carrying this out with modern transport at our disposal.

The proper repair of the perineum is a small matter, but of great importance to the ultimate well-being of the patient, and is a procedure which I consider, rightly or wrongly, is done more efficiently on the second day. It is essential to see what you are doing, and if the case has been a difficult one the patient and also the doctor have rested. I make frequent use of bipp as an application to the raw surfaces before stitching the perineum, and I carry in my midwifery bag an "Ever-Ready" battery and head-lamp. This is better than having your hair singed with a candle in a badly lit cottage. I have also found that a safety razor, which takes up very little room in one's bag, is frequently a useful article.

Emergencies

The dire emergency does not, I know, occur often, but it is an ever-present danger. It has occurred in my practice thrice in the last two years. I refer particularly to shock from sudden and severe haemorrhage. The patients in such cases must be dealt with in their own homes, which are frequently most unsuitable. In Newcastle-on-Tyne there has recently been established an emergency service whereby a practitioner, on being confronted with an emergency of this kind, can telephone to the Maternity Hospital and be provided immediately with a specialist, nurse, and all the necessary equipment for combating shock. I believe that in a trial case the emergency staff were in attendance at the house, which was some distance from the hospital by taxi, in fifteen minutes.

I feel that something on similar lines could be arranged in country districts by the local authority. The service could be supplied by the local hospital, and necessary equipment sent by car to any address.

During my long experience I have tried most of the antiseptics that have been fashionable from time to time. I consider that biniodide of mercury is the best for all-round use. I always use it for instruments, and dettol, which I have found satisfactory, for the hands.

In conclusion, I would like to say that in my opinion a great deal of harm is being done and undue alarm created among women by the publicity given to maternal mortality in the Press. In my own area it would be

difficult to better the service provided by the general practitioner. Any improvements in the maternity services of the country generally should be along the following lines:

1. A medical man and a midwife should be engaged for each case.
2. There should be a routine of ante-natal care in each case.
3. Where necessary aseptic equipment should be provided, to include such things as blankets, bedpans, dressings, etc.
4. A midwife or district nurse attending a maternity case should be relieved by a deputy from contact with other cases that are either suspect or septic.
5. Where necessary anaesthetics should be provided at the expense of the local authority. Maternity benefit is insufficient at present to enable the patient to make this extra payment.
6. An emergency service should be established in each area, and also a scheme of expert service available for all conditions at all stages.

HORMONAL REGULATION OF THE NUMBER OF BLOOD PLATELETS IN THE BLOOD

BY

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The constancy of the morphological composition of the peripheral blood picture is subject to nervous as well as to hormonal influences. That the number of erythrocytes is regulated by the thyroid hormone is a well-known fact; the administration of small amounts of thyroid hormone causes an increase in red blood cells in many cases (H. Zondek,¹ Bose,² and others). The increase begins about half an hour after the ingestion of 0.1 to 0.2 gram of thyreoidin, and that this is probably due not to an increased concentration of the blood but rather to an actual increase in the number of red cells in the blood stream can be shown by refractometric examination of the blood.

The following investigations deal with two questions: are the blood platelets also influenced by hormones, and, if so, which are the hormones involved.

Experiments with Thyroid Hormone

Method.—The patients received 0.1 to 0.3 gram of thyreoidin pulv. by mouth. The blood examinations were all carried out at the same time of day. The platelets were counted according to the methods of either Christensen or Fonio. The following tables give some examples of the results obtained.

TABLE I.—Male, aged 37. Diagnosis: Colitis

	Leucocytes	Erythrocytes	Blood Platelets
Before ingestion of 0.2 gram thyreoidin ...	11,000	4,000,000	230,000
½ hour after ingestion ...	10,000	4,000,000	280,000
1 " " " " " " ...	11,000	3,850,000	248,000
2 hours " " " " " " ...	11,200	4,300,000	265,000
4 " " " " " " ...	12,000	4,460,000	240,000
24 " " " " " " ...	14,000	5,000,000	360,000
48 " " " " " " ...	11,000	4,600,000	354,000
72 " " " " " " ...	13,400	4,800,000	221,000