MATERNITY SERVICES *

BY

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The public concern regarding the facts relating to maternal mortality and morbidity is unabated, and while the almost instinctive desire to scapegoat someone or something—the general practitioner, the midwife, the local health authority, and, of accepted custom, the Government—has been transmuted into an anxious recognition of the complexity of the problem, it must be acknowledged by those directly concerned that unremitting and unselfish devotion toward its solution is what is expected of us.

If the massive bulk of the literature on the various aspects of the subject were taken as an earnest of the set purpose to win through, then it would be but a question of time ere the goal of the irreducible minimum were attained. Much of the literature, however, does not deal with matters that are directly germane to that urgently desirable objective. A typical composite contribution gives considerable space to the comparison of the available statistics of many nations; discusses, usually by well-worn quotations, the fallacies incidental to the make-up of maternal mortality rates; draws favourable deductions in respect to a particular rate according with the nationality of the author, and, while admitting that the rate is no better than it should be, suggests that it is at least much better than the worst.

In the end all authors admit, and we agree with them, that any and every such national rate is capable of substantial improvement. In our own country there can be but few families, either within their own membership or that of close relatives, without record of a death which has contributed to the national maternal mortality rate.

But the literature abounds, too, with records that are the product of extensive researches on which, in respect to personnel, laboratories, and equipment, money has been expended without stint. They cover detailed inquiries, which are mainly biochemical and bacteriological, as well as others of a climatological, sociological, or seasonal character. Clinical technique has not been forgotten, and latterly, perhaps following on some significant vitamin reactions, the preventive effect of dietetic control, particularly in relation to puerperal infection, is being investigated. From all these sources new facts are being constantly contributed, and, added to what we already know, they constitute an almost overwhelming fund of information on which to draw.

I apprehend that the purpose which the committee of this Section has in mind is that my colleagues and I should submit jointly for consideration and discussion such information and opinions as we possess concerning the maternity services at present available in this country. From such a conspectus, submitted to discussion, it may be anticipated that points essential to a creditable maternity service will emerge. It is not, I gather, expected—at least, I hope not—that from our deliberations yet another national maternity service will find expression in published form.

My terms of reference as the introducer of this discussion include the submission of a general survey of maternity services at present available. I have interpreted this as excluding the detailed figures of the great and

steadily increasing number of local authorities who take seriously their obligations and responsibilities under the maternity and child welfare and other allied enactments. And as there are few, if any, maternity services as such which have neither an administrative nor a financial relation to the health authorities, it would be difficult to detach wholly a substantial group of maternity services and deal with them separately.

Principal Factors

If it be difficult to make a satisfactory general survey of maternity services as to form and scope it may be useful shortly to discuss the principal factors in their make-up, actual and prospective.

First then the mother. Whatever justification there may be for a semi-terrorist campaign in regard to cancer, it is certain that maternity-care propaganda to be helpful must be conducted on lines of reassurance and not of menace. The susceptible nervous system of the pregnant woman is readily impressed by a recital of possible complications, even to the extent of what has been termed anxiety neurosis—a very unwelcome accompaniment. An essential objective to ensure the success of maternity services is to gain the confidence and support of women generally.

Ante-natal and Post-natal Care

Many evidences are available which go to show that that confidence is steadily being won. Among them is the growth in the number of, and attendances at, ante-natal clinics, of which we shall hear later. But those numbers are far from representing all the ante-natal care which is being carried out. A considerable, and probably much greater, amount is being effected by private practitioners.

Some of my fellow-teachers present will agree that for the past few decades the training of medical students in obstetrics has been very different from that which we underwent as students, in particular as regards ante-natal care and what Ballantyne termed ante-natal pathology. Judged by the age-standard of other branches of knowledge ante-natal science is young. Mistakes and unverified prognoses are inevitable, but experience is being gained and new facts established and recorded to afford a stable basis on which advice and treatment are being founded.

Such considerations as these are not, presumably, in the minds of those who express disappointment with the results of the much extended ante-natal care in clinics and in private practice of recent years. I am in entire agreement with the view that competently conducted ante-natal clinics are rendering very valuable maternity service, and that that service will be further enhanced by the experience which is being accumulated on so large a scale. No one, I think, will dispute the advantages of the material benefits dispensed by the clinics to those otherwise unable to obtain them. Incidentally they afford, too, an avenue whereby, in a general way, some dietetic reactions in pregnancy may be observed.

That post-natal care should be the corollary of the ante-natal clinic will scarcely be denied if regard be had to the generally accepted statement that of cases attending gynaecological out-patient departments no less than 40 per cent. have a causal relation to obstetrics. If the criticism be well-founded that at post-natal clinics there is a tendency to recommend operative treatment for conditions which, given reasonable time, are naturally curable, it can with greater cogency be urged that very many cases coming to the gynaecological department exhibit aggravation and complications that could have been avoided by early post-natal care.

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

The Midwife

The midwife may make or mar the success of any maternity service. For that reason the form in which the Bill now before Parliament reaches the Statute Book is of critical importance. In its provisions it is evident that the inevitable disturbance of vested interests which such a measure entails has been foreseen, and, up to a point, I think, fairly met by the Minister. In him we recognize a statesman who is anxious by means of fair dealing to launch his Bill on the appointed day in an atmosphere of good will—in no sphere more indispensable to effective working than in that of midwifery. To that end, in the matter of compensation, may we say that it will be a good investment to make provision for some generosity rather than for mere actuarial justice. I am sure I may state that we regard the provision for direct consultation and co-operation by local authorities with existing voluntary agencies as vital to success.

Take, for example, the Queen's Institute of District Nursing, which, judged by present-day standards, has for many years rendered high-grade midwifery service not only in cities and large towns but in many rural areas where no other agency has even blazed a trail. The administrative experience gained by the Institute centrally and through its affiliated associations will be invaluable under the new conditions, and probably exemplary to some of the officers of local authorities framing their schemes under the Act. The traditional co-operation of the Queen's nurses with general practitioners will make for smoothness of working.

This brief reference to the Midwives Bill is made mainly for the reason that from its commencement and thenceforward a fundamental section of the maternity services of this country will be largely recast, with its administration in the hands of the local authorities under the general control of the Ministry of Health. It is a prelude, and I think a necessary one, to any effective national maternity service, in that, *inter alia*, it will automatically remove the surplus midwives from practice, and will, on the average, enhance the conditions of service and emolument of the midwives employed, together with the status of their calling. But it will take some time for this foundation of a national service to consolidate, and there may be some reactions not at present clearly visualized.

May we take this opportunity of offering our congratulations to the Joint Council of Midwifery and particularly to the Chairman of its Midwifery Services Committee, Dr. T. Watts Eden. It is understood that it is mainly on the committee's report that the Bill has been framed.

The General Practitioner

A national maternity service which excludes the general practitioner from its responsible personnel is impossible and unthinkable. The State which requires, through the General Medical Council, that he must pass, equally with medicine and surgery, a recognized examination in obstetrics in order to register could not condone such an omission. But apart from that, in domiciliary practice, which comprises and will continue to comprise the bulk of confinements in this country, the general practitioner is in the first line.

There are practitioners who, through preference or for other reasons, do not take midwifery, but among the remainder—and on this I am sure my teacher-colleagues will agree with me—there are not a few but very many who, in knowledge, experience, and technique, are first-class obstetricians. Instances must be known to many of us of practitioners, declaredly, not taking midwifery, and that without detriment to their status in other spheres of

their practice. Again, there are general practice partnerships in which the midwifery is undertaken by one of its members, who may have taken a diploma in obstetrics.

The principle of continuity of individual medical supervision under conditions of free choice has much to commend it. But, in a general service, it may be very difficult to achieve. Its attractiveness is all the more marked when compared with its antithesis, which is not infrequently exemplified under prevailing conditions.

A young primigravida having a few months previously entered upon the curriculum of motherhood submits herself to the preliminary and more or less scientific examination by a midwife; later, after having received at a clinic much information on various subjects, one or two of which are more or less cultural, she undergoes a *first* and even a *second* professional examination by duly registered medical practitioners. The final test and its evidences are normally unmistakable, and within the statutory quota of days the related certificates are available.

Further merit may be acquired by attendance at a post-graduate course represented by a post-natal clinic. In each of these stages our primigravida-primipara may encounter different personnel, and she has good reason to complain that her motherhood curriculum is overloaded and highly departmentalized.

Some of us are familiar with the analogous submission from our medical students. Albeit, their curricular interests are—shall we say?—rather less subjective than those of the mother.

The Consultant

The consultant does not "butt in"; he is called in. He consults, not with the midwife, but with the general practitioner. He is essential to a maternity service. The great majority of confinements are normal. In not a few there is abnormality with which the general practitioner is perfectly competent to deal. There is, however, a much smaller number which, in common fairness, no practitioner should take the responsibility of managing single-handed, and in which, provision having been made for consultant services, it is his duty to call in a consultant. Usually this is gladly done. One of the advantages of a recognized maternity service is that its complementary factors involve no reflection on the convoking of colleagues under conditions. It is the proper thing to do.

Hospitals

The hospital is an indispensable adjunct of a maternity service; but there are hospitals and hospitals. The home is infinitely safer than the carelessly conducted hospital. The contingent reservation of beds in a mixed hospital where separate nursing and administration are impossible is not to be commended. But even under such conditions, given skilled and discerning nursing, the results may compare favourably with those of much more costly and elaborate hospitals where blind reliance is placed upon the structural separation of the maternity department. I said advisedly "*may compare favourably*," but, other things being equal, the average comparison is unfavourable. In other words, knowledge and skill being available in both instances, the better structural conditions give better results. For some time to come, however, the only provision in very many rural and in some urban areas will be by reservation of beds in a mixed hospital. Apart from being a meeting place for co-operation between practitioner and consultant, the hospital affords the means of gaining that blessed relief which comes from practitioners in the area sharing the anxieties and responsibilities of difficult midwifery. Further, in its measure, it is a basis for ante-natal supervision and a contribution to the time-factor in labour which is so important in diminishing the "interference" rate.

There is, indeed, no wonder that the number of women of all classes seeking institutional accommodation for their confinements is steadily increasing. For this there are good reasons, and among them the freer availability of analgesia is not the least. The availability of analgesia and/or anaesthesia for parturient women is truly a worthy objective.

The attractions and advantages of maternity hospitals notwithstanding, the conduct of, and the equipment for, domiciliary midwifery will remain the centre of the whole problem, and will, in the main, control the mortality and morbidity rates.

Administration

As regards administration some would urge that, as the Rochdale example would seem to indicate, with sustained good will and co-operation on the part of all the personnel and institutions concerned, strikingly good results may accrue even without further legislation than exists at present. This may be true on the small scale, even after making due allowance for the change to be brought about by the Midwives Bill when it becomes an Act, but the majority view is that, for a national service, both central and local advisory bodies with suitably representative membership and with responsible status would be necessary if that indispensable element to success is to be fully enlisted—namely, the confidence of the doctors, of the midwives, and of the public.

MATERNITY SERVICES: THE PART PLAYED BY EDUCATION OF MEDICAL STUDENTS*

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In dealing with the teaching in the medical schools and the ways in which it may be improved I have felt it necessary to present not merely my own views but also, so far as possible, those of other teachers. For the purposes of this discussion, therefore, I sent a questionnaire to chiefs of maternity departments in twenty-two medical schools in Great Britain and Northern Ireland. In all twenty questions were asked, but space will only allow me to indicate in a general way some of the more important results.

Let us start with the assumption that whatever is to be the future of maternity work in this country the services of the general practitioner are at present indispensable. An increasing number of the leaders of thought in these matters see the ideal scheme as one staffed by highly trained specialists, but for the time being the personnel to work such a service does not exist, and to attempt to start it on a large scale with people inadequately trained would be to court disaster. Further, there is no doubt that many patients, especially of the better class, will continue to demand the moral support of their family doctors in one of the greatest crises of their lives. The service can thus at best be only an alternative one. I shall therefore try to indicate the ways in which undergraduate teaching and experience may be improved.

Clinical Experience

An increase in the number of beds is, I contend, urgently necessary. In the twenty-two schools to which my questionnaire was sent there is an annual entry of 1,800 students, but only 1,400 obstetric beds are available for teaching them—that is, less than one bed per student. Half the schools have fewer than fifty beds. In two the number of beds is twelve, and in one it is thirteen, yet these three schools between them admit 142 students annually, or four students to each midwifery bed. It is generally agreed that a hospital of less than fifty beds will not provide sufficient variety of material to enable any number of students, however small, to be trained properly.¹ If our voluntary hospitals are unable or unwilling to provide an adequate number of beds for the training of students one of the chief reasons for their continued existence will have disappeared.

Recommendations of the General Medical Council

Compliance with the recommendations of the General Medical Council should be enforced. I believe I am right in saying that not a single school in this country complies with these recommendations in so far as the teaching of midwifery is concerned. Let us look at one or two of them. One of the most important is that the maternity student should live for at least two months in the hospital or in quarters adjacent thereto. This condition is fulfilled in only nine of the twenty-two schools to which the questionnaire was sent. Again, it is recommended that six months should be devoted to clinical obstetrics and gynaecology including child welfare, but in only half the schools is the time *nominally* six months. The student should devote the whole of that six months to these subjects with the exception of the time necessarily taken up with attending systematic lectures, yet this condition is complied with in only ten of the twenty-two schools.

Again, the student's time should be so divided that approximately two-thirds is devoted to midwifery and one-third to gynaecology. Only four fulfil this requirement; in the others far too much time, sometimes much the greater part, is spent on gynaecology, and in several medical and surgical paediatrics are studied at the same time. The recommendations also provide that the student should attend and personally deliver at least twenty lying-in women. The average number in the twenty-two schools is about seventeen, and in some the number is as low as five or six. Is it surprising that only four of the twenty-two chiefs of departments who replied to the questionnaire described themselves as satisfied with the teaching as it is done at present, or that one despondently expressed himself thus: "Gifted with an uneasy conscience in endeavouring to discharge my duties as a teacher adequately for the past sixteen years, I only succeed in undermining my health and producing a second-rate race of obstetricians"?

You may agree with me in wishing that the General Medical Council would begin to exercise the great powers it possesses under the Medical Act of 1858 and "put the general interest of medical education before the particular and limited interest of the bodies or institutions" its individual members represent. If the Council does not regard the statutory powers it possesses as sufficient, it should seek them, for peaceful persuasion has obviously failed.

Teaching in Relation to the Needs of the General Practitioner

Opinion is divided regarding the value of systematic lectures, and the practice of schools varies widely in this respect. Some teachers give fifteen lectures yearly, and

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