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OBSTETRICS IN THE NATIONAL HEALTH SERVICE

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In writing an article on this subject there are obvious difficulties. In the first place, as I write (March, 1949), the Service is only eight months old; secondly, there may well be changes before publication takes place; and, thirdly, in domiciliary midwifery probably no one knows exactly what is happening unless it is the supervisors of midwives.

July 5th, 1948, was the date fixed for the introduction of the National Health Service and nothing would influence the Minister to alter that date or to take over the medical services of the country by steps, in spite of advice from the profession that the undertaking was too big to do as a whole. We who work in a medical capacity were fully aware of the various shortages of medical personnel, of nurses, midwives and of institutional beds, and felt that any increased amount of work would strain medical services to breaking point. We were aware that the promises of increased medical benefits were impossible of fulfilment, and already we have seen that the Minister has had to appeal to the people not to demand medical benefit except in cases of the greatest urgency.

It is a sad thing that such promises were ever made as it can only mean that medicine and even the maternity services have become counters in party politics.

At the end of March or beginning of April, 1948, a member of the Government said in a broadcast, 'Every woman will be able to choose a midwife or doctor, and the doctors will have had special experience of midwifery work. It will be impossible for a young mother after July to have a newly-qualified doctor without experience . . .' This simply is not true today. The Ministry started off with the view that doctors undertaking midwifery in the Service should have had experience in the subject. Later the Regulations were amended so that every doctor, with or without previous experience in midwifery, could attend patients on his own list in the Health Service.

Professor Chassar Moir wrote a letter on this subject in the *Sunday Times* of August 1st, 1948, and I will quote part of it:—

'Medical statistics are sober and—scientifically speaking—sacred facts. So at least it might be supposed. But these statistics are fast becoming the plaything of politics. With scant regard to their true meaning or to the trends they indicate—or, for that matter, whether sometimes they mean anything at all—the figures may be wantonly seized and, as it were, stored as ammunition ready for discharge in the next political battle. A prostitution of science.

'In a recent broadcast, Dr. Edith Summerskill stated: "Further we have the lowest death rate among mothers in childbirth ever recorded. I remember before the war campaigning in the interests of women in childbirth and pointing out that it was a more hazardous occupation than mining." As the paragraph from which this extract is taken was sandwiched between two others dealing with changes in diet of the population (for which Dr. Summerskill claimed credit for her party) the passage clearly implied that the reduction in maternal deaths was the result of the present Government's action.

'Last week Mr. Aneurin Bevan is reported to have compared a long list of medical statistics of 1926 with those of 1946, implying that improvement in recent times has been the result of a new policy in the Ministry of Health.

'But has improved medical practice nothing to do with the change? Has not similar improvement taken place in other comparable countries?

'If credit is to be given for the wonderful improvement in maternal mortality statistics, let us honour those who brought about the improved control of sepsis, those who introduced the sulphonamide drugs and penicillin, and—no less—the innumerable midwives, medical practitioners and obstetric specialists who each in his own way contributed to the steady improvement that has taken place over a decade and more.'

In May 1944 the Royal College of Obstetricians and Gynaecologists published 'A Report on a National Maternity Service' in which the position of obstetric practice at the moment was discussed. There had been a fall in maternal mortality in previous years, but it was felt that it was still too

high. The fall was considered to have been due to improvement in the treatment of shock and haemorrhage, to the use of new drugs in cases of sepsis, to the improved methods of investigating and preventing puerperal infection, to the increase in institutional midwifery and to the successful efforts of some local authorities to improve their midwifery service, but not so much to improvement in the practice of obstetrics as it should have been. The last figures available for use in that report were those of 1942, with a maternal mortality rate of 2.5 per 1,000 live births; there has been further improvement since then and the figures for 1947, the last available, were 1.20 per 1,000 live births.

In its report the College recommended a few essential principles without which a successful maternity service could not be built :—

1. *Unification of Control*

In the National Health Service, midwifery is under three authorities as laid down in the Act.

(a) The Hospital and Consultant Service is under the Regional Hospital Boards or Board of Governors of Teaching Hospitals.

(b) General practitioners are responsible to the Local Executive Council, while

(c) Midwives, etc., are responsible to the Local Health Authority.

Before the Act was passed the Royal College of Obstetricians and Gynaecologists tabled an amendment when the Bill was in Committee stage, praying for the unification of the midwifery services under one control. The Chairman of the Committee did not even call the amendment for discussion.

May I give you one example of this lack of co-ordination in domiciliary midwifery? More patients are booking with doctors for their confinements and consequently fewer with midwives. In one place, strong-minded midwives advised their patients not to engage doctors as it was unnecessary in normal cases; they could always be called in if a condition arose which necessitated it. The local authorities still pay doctors for midwives' aid calls, so this authority soon notified its midwives that domiciliary patients were to be booked with doctors as the Ministry would then have to pay the doctors' fee, thus reducing its own expenditure. So the normal midwifery is being deflected from midwives to doctors because of the method of payment of fees. Not a good reason and one which could not have occurred if the whole of midwifery had been under one control.

2. *Normal Midwifery*

That normal midwifery should remain as it has been in the hands of midwives. In 1947, 86 per

cent. of all patients in England and Wales were attended by midwives.

In this connection I quote from the report of the Inter-Departmental (Goodenough) Committee on Medical Schools :—‘In the conduct of labour the pupil-midwife has more technical experience during her training than the medical student, and it would be neither wise nor economical to encourage competition between midwife and medical practitioner for the care of normal labour. The conduct of a normal confinement is the primary and essential obligation of the midwife to the community. The medical practitioner has many others which may be both urgent and exacting.’

3. *Qualification of General Practitioner Obstetricians*

That there should be a list of practitioners qualified to be called in for midwives' emergencies and the qualifications should be :—

(a) To have held a resident appointment in obstetrics ;

(b) To have had a long experience of midwifery in practice.

It was foreseen that in rural areas it might be necessary to put all the doctors on the list, whether they had either type of experience or not.

4. *The Local Obstetric Committees*

That local committees should be set up consisting of the medical officer of health, a specialist obstetrician and a local practitioner, to establish and maintain the above list. That Ministerial guidance should be given to these committees on the principles involved in selecting the general practitioner obstetricians.

Local committees were set up but no such guidance nor indeed advice has been granted by the Ministry in spite of requests from several different areas.

These committees, the medical officer of health being one of the members, should have been entitled to sufficient information on the midwifery practice of the applicants who had not had the prescribed experience for admission to the list. In the medical officer of health's office are the records of notification of births, of midwives' aid calls, of puerperal pyrexia, of the maternal and neonatal deaths. The consideration of this information would have enabled the committee to have a very shrewd idea of the applicants' obstetric capability or lack of it.

Institutional Midwifery

In the 14 Regional Boards responsible for the hospital service (except that of the teaching hospitals) there is no common plan for running the hospital maternity services. Some Regional Boards contain obstetricians among their mem-

bers ; some of those who do not, have an advisory obstetric committee at Board level, though at least one region has neither an obstetrician on its board nor an advisory obstetric committee. It must follow that boards which have neither obstetricians as members nor an obstetric advisory committee are neglecting obstetrics and gynaecology.

In most regions it can be said that the Hospital Boards are doing their utmost to produce a good hospital service in obstetrics and gynaecology and are succeeding. The following notes on what is happening in three Regional Hospital Board areas are reliable and will give the reader an idea of how the problem is being met ; they consist of one Metropolitan and two extra Metropolitan Regional Boards.

Region 1 has an obstetrician on the board ; arrangements have been made to set up advisory committees on midwifery in each Hospital Group Area. These committees will consist of :—

The Consultant Obstetrician.

The Deputy Consultant Obstetrician.

The Medical Officer of Health.

One General Practitioner nominated by the General Practices Committee.

One Supervisor of Midwives.

One Health Visitor.

They will advise their Group Hospital Committee on local requirements and through it can put problems up to the Regional Board. A maternity committee at Regional Board level has been set up though it has not yet met. This Regional Board is paying particular attention to the production of a satisfactory hospital maternity service in those areas where the service is rudimentary at present. In such areas a population of $\frac{1}{2}$ to $1\frac{1}{2}$ millions, and towns of 100,000 are included, and where there is no properly trained obstetrician, appointments have already been, and are being, made. In other areas where properly trained obstetricians already practise, the available resources, beds, obstetricians, midwives, equipment, etc., have been reviewed and a plan formulated for using them to the best advantage. In the reconstruction of old units and in the planning of new it is accepted as a principle that specialists in obstetrics should also have gynaecological beds as soon as this arrangement can be implemented.

In a district on the periphery of this board's area it is proposed to run a hospital maternity service for a well-populated district which lies half in this board's area and half in that of the neighbouring Regional Board. The medical personnel involved has expressed itself as unanimously in favour of this scheme ; let us trust it will not be ' too difficult administratively.'

Region 2 has an obstetrician as a member of its board, and acting on the advice of its medical advisory committee has agreed so far on certain principles in respect of the midwifery services. In the first place they are linked with gynaecology, and the development in each part of the region is a combined obstetric and gynaecological development. In each particular part of the region there is a key hospital in most of the large cities and towns, and it is planned to develop further such hospitals as is found necessary. In the meantime all the units in smaller and outlying centres are linked with the central department of the nearest key hospital, and the responsibility for the work done in these subsidiary centres rests with the director of the central department. This was planned deliberately as an alternative method to the one suggested in the Ministry's document on the development of specialist services. In this it was implied that in each hospital of 100 beds or more there should be a resident physician, surgeon, obstetrician and gynaecologist. An endeavour is being made to develop along these lines already mentioned for two reasons. In the first place it is believed that in this way provision can be made for a much better service in that the more difficult cases will be selected and sent to properly equipped institutions where they can be dealt with by the more experienced officers. Furthermore, it is felt that by linking these subsidiary units with the centre, the board could increase the establishment of specialists in training at the centre and in this way be of more help in providing ever-increasing facilities for the training of the next generation of obstetricians and gynaecologists.

The board has already organized flying squad services to cover the whole region, based on the key hospitals to which reference has been made, with further assistance from others, which, though outside the region, are better situated geographically to provide an emergency service to the adjacent parts of this region than are the key hospitals within the region.

All obstetric admissions to the available units in the region are now made either on medical grounds or on social grounds. The obstetricians in charge of the clinics admit only those patients whose medical or obstetric condition makes institutional delivery advisable. Only those normal patients, whose home conditions have been investigated by the health visitors attached to the respective medical officers of health and found unsatisfactory for home delivery, are admitted to the maternity units. This is the result of instructions given to the Regional Boards from the Ministry. In the interpretation of these instructions the board has already found that there are dangers. For example, a medical officer of health can arrange by

telephone for his patient to be confined in hospital. "A" and her ante-natal care will be carried out by the local ante-natal clinic or by a midwife or a doctor. She may then arrive a fortnight post-mature in the maternity unit with severe toxæmia, severe anaemia or some other as yet undetected complication. Having had a surprisingly large number of such cases, the medical officers of health have now been requested to send to the hospital ante-natal clinic those particular patients for admission to the maternity unit and to send them as early in pregnancy as possible. The question of the subsequent ante-natal care is then the responsibility of the officer in charge of the unit ante-natal department of the centre or key hospital. Having seen the patient once and having arranged to see her as often as he considers necessary, he can reasonably be expected to accept responsibility for her subsequent progress, which it would be unfair to ask him to accept under the system as previously interpreted by the medical officer of health.

In the smaller maternity units where there are approximately 30 beds, a local practitioner interested and experienced in obstetrics and possibly holding the D.Obst.R.C.O.G., has been appointed in charge of the unit and is responsible to the central department. An attempt is being made to expand this type of liaison throughout the whole region. The board is also endeavouring to implement the idea that the ante-natal care of all patients should be supervised by the doctor responsible for their deliveries. At present, by negotiations between the various authorities, it is hoped that the ante-natal clinics hitherto run by local authorities may ultimately be linked more closely with the specialists in the central department.

In all its developments the region is emphasizing the importance of parallel development of its obstetric facilities with the services of its paediatric colleagues. A paediatric flying squad has been started which at present is based on the maternity home and is used for the bringing of premature infants into the hospital. It seems already that this can be life-saving and, if the work it can do is satisfactory, the service will be expanded throughout the region.

It may be added in conclusion that this region is fortunate in having colleagues in all its key centres who are anxious to co-operate to the fullest in providing a good regional service. To encourage this the board is instituting periodic clinical and discussion meetings at each key hospital so that the staff from registrar level upwards in all key centres can see what is going on elsewhere and can benefit by the exchange of ideas.

It will thus be seen that the board's plan for

development is based on the formation of key hospitals with peripheral connections.

Region 3. This region also has an obstetrician on its board which appointed an Obstetric and Gynaecological Advisory Committee from names nominated by the Medical Advisory Committee. The Obstetric and Gynaecological Advisory Committee consists of members from different areas in the region with a total membership of seven. The committee's instructions were to integrate the hospital service and to co-ordinate and link up neighbouring hospitals and maternity homes.

The committee has surveyed the existing facilities available and submitted plans for long-term and short-term policies. Long-term policy cannot be implemented till further building and accommodation are available. Short-term policy has been planned in considerable detail as being the only practical proposition for many years to come.

The short-term plan provides:—

(a) Specialist services where they were not previously available.

(b) Adequate cover for each area to avoid one-man control and to make local specialists in small areas less tied. Prevention of isolation and consequent stagnation of specialists in outlying areas, by giving them facilities for work at, and recognized status at, a major hospital centre.

(c) Specialist control and cover in maternity homes attended by general practitioner obstetricians.

(d) That the fullest use shall be made of available beds.

(e) The means of integrating the services in small areas with those in larger areas and in key hospitals.

Domiciliary Midwifery

From the reports one hears from various sources, e.g. midwives, obstetricians, etc., it appears that the domiciliary midwifery service is not as yet satisfactory. It has been stated that 93 per cent. of the population have put their names on doctors' lists. This leaves 7 per cent. of paying patients and if for the sake of accuracy we add 5 per cent. to this figure and call it 12 per cent. we shall not be far out. In effect practitioners who had good middle class practices with no panel, or a very small one, now see all their paying patients on their lists and for them they are to be paid a capitation fee which amounts to approximately 15s. 6d. These men who were the cream of general practitioners and who earned anything between £2,000 and £3,000 a year, now have a list containing 1,000 to 1,500 patients at 15s. 6d. It does not need an arithmetician to tell you that their incomes have been cut down by more than

half. These practitioners do not have a list full to capacity, that is to the figure of 4,000 which is allowed by the Ministry, for the very good reason that they are accustomed to do their work without consideration of time. They cannot bring themselves to rush through a surgery overcrowded by patients and to postpone visits to patients until the next week or later. To these unfortunates whose income has been so heavily reduced, the £7 7s. od. per maternity patient became very important and they have been driven to undertake all the midwifery that they can collect. Then along comes Mrs. Smith who says:—‘ Doctor, I should like you to be present and deliver me,’ and he agrees. She is a woman he has known for years and probably her family too. Every other Mrs. Smith, not to mention Mrs. Brown, Jones and Robinson, demands the same attention. The other doctors in his area volunteer the same service; there is competition for the midwifery patient. I have little doubt they will do it conscientiously and to the best of their ability even if they kill themselves in the process. Many of these practitioners are anxious to obtain more experience in midwifery and it is hoped that it will be possible to find some means by which they can do so.

Thus normal midwifery has been taken from the midwife and she becomes a maternity nurse. She does not see her patient in the ante-natal period, she attends the confinement and may suddenly have thrust upon her in the absence of the doctor, the responsibility of delivering the woman and in the puerperium she reverts to the maternity nurse again. No reasonable person has any doubt that this will react against the recruitment of midwives who undertake their arduous profession because it gives them a feeling of responsibility and a pride in a job well done. ‘ The Working Party of Midwives ’ set up by the Ministry has recently published its report. Several pages (pp. 23-29) are devoted to the midwife’s place in the health team and I recommend them to your notice.

What can be done to improve the Domiciliary Midwifery Service ?

Any of you who have read the National Health Service Act will have seen on page 1 a reference to a body called the Central Health Services Council. It is a committee which has the duty to advise the Minister and to make an annual report of its proceedings and of the proceedings of any Standing Advisory Committee constituted by the Minister after consultation with the Central Health Services Council. The Presidents of the three Royal Colleges are members of the Central Health Services Council.

There has been constituted a Midwifery and Maternity Standing Advisory Committee and the names of the members have been published in the press. You will have seen that I have accepted an invitation to serve on it. This committee is certain to consider domiciliary midwifery at one of its earliest meetings.

I would suggest the means by which the midwifery service can be improved are:—(1) The establishment of a single statutory authority responsible for the maternity service of the whole country. If this is not practicable, (2) setting up a Statutory Maternity Committee at Regional Board level which is responsible for all the midwifery of the region, both institutional and domiciliary. If neither of these things can be done, (3) a Maternity Advisory Committee should be appointed at the Regional Board level, which consists of an equal number of representatives of the Board, of the local authority in the region and of the Executive Councils within the region, together with representatives of the obstetricians on the staff of the teaching hospital within the region. It should be the responsibility of this committee to plan an integrated hospital and domiciliary maternity service. This paragraph was written before I had read ‘ The Report of the Working Party on Midwives. ’ Its paragraph 104 supports my suggestion and reads, ‘ We find that in some areas no joint machinery exists for discussion of the midwifery functions of Regional Hospital Boards, Local Health Authorities and Executive Councils. We think it is important that those actually working the service should have an opportunity of shaping it with those representing the administrative bodies concerned. We recommend that in each Hospital Region a Maternity Services Committee be set up to include obstetricians, general practitioners and midwives. ’

Most of us are aware that the general practitioner obstetrician lists are a farce, as in some districts the whole of the doctors in that area have been put on the list and in a few places the list has been established efficiently. Again the whole idea of putting domiciliary midwifery practice in the hands of practitioners with experience in the subject was compromised when the Ministry amended Regulation No. 506 so that any practitioner, however deficient in obstetric experience he might be, could attend patients on his own list in their confinements.

The very nature of obstetric work with its occasional sudden unpredictable complication makes it necessary that those doctors who practise midwifery should have had clinical experience in it. It should be the duty of the responsible body mentioned above to set up qualifications for practitioners who entered the Service on July 5th,

1948, and wish to take part in obstetric work. These might be :—

(1) To have held a resident appointment for six months in obstetrics in the maternity department of an approved general hospital or in an approved maternity hospital.

(2) To have done midwifery in private practice over a period of years.

(3) To make it a condition that those practitioners entering the service after July 5th, 1948, who wish to do midwifery must have had a resident post as mentioned above.

If such conditions are laid down it becomes

necessary (a) to ensure that there are sufficient resident posts of this nature for the recently qualified ; (b) to evolve a scheme which will enable established practitioners to hold a resident post if they are anxious to qualify for this part of the Health Service.

In spite of the economies already affected in the Health Service I am confident that if all those who work in the maternity field are willing to co-operate wholeheartedly, an organization can be developed which will give satisfaction alike to the patients and to those responsible for their safety, whether Minister or midwife.

FOREWORD—(Continued from page 290)

We can only hope that under the maternity provisions of the National Health Service the avoidable deaths will not show an increase. The Ministry of Health has means at hand for finding this out. For many years now, confidential reports on all maternal deaths are sent to Whitehall. It was on these reports, analysed by a small body of independent obstetricians, that the Ministry based the figures given in their 1932 and 1937 reports. So far as I am aware no such analysis has been made, or made public, since. It is to be hoped that this sort of accountancy will be published after the first full year of the new Service.

No doubt the remarkable fall in maternal mortality (which started long before a Labour Government took office) may have given the Minister and his official advisers a sense of complacency. But in view of the remarkable life-saving factors that have been at work during these years of fall (penicillin, the sulpha drugs, blood transfusion), it would have been much more remarkable if the deaths had not fallen to their present level. There is indeed no cause for complacency.

I would mention also modern Caesarean section (which term should include the anaesthetic) as one of the life-saving factors ; that is, when done by those who know, and fewer and fewer sections are being done by those untrained in the modern way. Placenta praevia is an example of a once highly

dangerous complication that has been made relatively innocuous and I am very pleased that Professor Macafee has contributed a paper on this subject. He has become the acknowledged authority, whose well-recorded work over a series of years has shown how not only the maternal but also the infant wastage can be kept low. Another example is the prolonged labour due to uterine inertia (to use the old term), to which Mr. Clayton rightly devotes a good deal of his paper. I have never known this difficult problem—one of the most difficult of all—discussed with more insight, with the argument well buttressed by facts. Indeed Mr. Clayton's scholarly and at the same time practical paper will be of great assistance to those young gynaecologists who may on occasions be bewildered about how, when or whether to do a section on a particular patient.

At the Congress, modern Caesarean section is to be discussed at the first morning session, introduced by Mr. MacIntosh Marshall, whom I like to regard as the young master of the operation, as we all regard Munro-Kerr as the old master. The old master, that is, not of Caesarean section only but of the whole art of difficult obstetrics. Our gallery would be incomplete without the portrait of him whom we all acknowledge as the first British Obstetrician of his generation ; Scottish, too, as are three other great men whose portraits appear—Smellie, Simpson and Tait—as the frontispiece of this most excellent special number.