SOME SUGGESTIONS FOR AN IMPROVED MATERNITY SERVICE

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THE OBJECT OF THIS PAPER is to demonstrate how postgraduate education offers considerable improvements in our maternity service. Of course, it must not be forgotten that equally important is the need to improve the facilities available to general practitioners, and possibly the forming of more general-practitioner maternity units throughout the country would be the ideal means to this end.

Aims

1. *To reduce further the maternal mortality*

Provisional national figure 1963 = 0.28 per 1,000 total deliveries. In 1958 to 1960 there were 928 maternal deaths in England and Wales.[1] Of these 742 were critically reviewed and 315 (42.5 per cent) were found to have avoidable factors. Of the 315 the cause was attributed to:

85—Consultant and staff
136—General practitioner
91—Patient
19—Medical officer of health

2. *To reduce maternal morbidity*

Physical damage could be avoided by less traumatic obstetrics, and mental damage lessened by adequate preparation for and good conduct of labour. Furthermore, if the baby is born alive and well, the mother would be spared the frightful mental scar that is seen in less fortunate mothers—sometimes still with them years later.

3. *To reduce further the perinatal mortality*

Provisional national figure 1963 = 29.3 per 1,000 total births.[2] Recently published is the first report of the British Perinatal Mortality Survey, a review of 16,994 singleton births in Britain from 3–9 March 1958—during this 666 (38.7 per 1,000 total births) perinatal deaths occurred. These figures have been analysed by a committee under the auspices of the National Birthday Trust Fund,[3] and have revealed some considerable deficiences of the obstetric service. To take one point—only 40.9 per cent of the population were booked and delivered in a specialist unit. 53.4 per cent booked with the general-practitioner obstetrician (alone), and 5.7 per cent were booked with a midwife (alone) or quite unbooked. 48.5 per cent remained with the general practitioner throughout, whereas 9.1 per cent of the total were transferred to the specialist unit either later in pregnancy or in labour. It was from a closer study of these figures that the committee considered that the general practitioners in the country as a whole must have contributed in considerable part to all these peri-

natal losses. *N.B.*—In Chelmsford from 1960 to 1963 there were 14,286 consecutive births, and of these 7,100 (50 per cent) were managed entirely by general-practitioner obstetricians: yet the perinatal mortality, overall, was only 23.3 per 1,000 total births. This figure proves beyond doubt that if the Chelmsford midwives and doctors (general practitioner and consultant) can achieve such good results so should the country as a whole—and the above British Perinatal Mortality Survey figures could be considerably improved. (Tables I and II).

TABLE I

CHELMSFORD AREA FIGURES DEMONSTRATING THE GREAT IMPROVEMENT IN RECENT YEARS IN SPITE OF MANY COMPLICATED CASES FROM OUTSIDE THE AREA

	1960	*1961*	*1962*	*1963*	*National figures*
Maternal mortality per 1,000 total births	0·31	0·28	0·27	Nil	0·28 (1963) provisional
Perinatal mortality per 1,000 total births	30·6	24·9	19·1	21·2	29·3 (1963) provisional

The 4 years total births = 14,286
The 4 years perinatal mortality = 23·3 per 1,000 total births

TABLE II

PLACE OF DELIVERY

Year	*St John's (Specialist unit)*		*General practitioner units*	*Home*	
	Total	*Percentage*	*Total*	*Total*	*Percentage*
1960	1679	*51·9*	644	909	*48·1*
1961	1843	*52·9*	664	1007	*47·1*
1962	1729	*47·1*	769	1170	*52·9*
1963	1786	*48·0*	865	1072	*52·0*

4. *To prevent damage to the baby during birth*

As a result of anoxia, disease, jaundice or prematurity during or after birth, these babies so damaged might develop spasticity or mental deficiency—there are 70,000 spastics in this country at the present time, and it is possible that at least 25 per cent[4] might have been avoided had we had a perfect obstetric service.

Methods

1. *The undergraduate* (medical student)

The primary obstetric education of the medical student cannot be

improved much as there is insufficient time in the already crowded undergraduate syllabus. In most medical schools obstetric teaching continues for two months only (generally one month in teaching hospital and one month in a peripheral hospital): in some it is for three months.

2. *The postgraduate*

It is essential that each doctor proposing to practice obstetrics in general practice should undertake at least six months as an obstetric house surgeon in a busy obstetric department. This department should be delivering a minimum of 1,000 patients a year, and the house surgeons should be thoroughly and regularly taught by the consultants, i.e., they should not be left to their own devices. At the present time, by no means are all doctors entering general practice trained in this way, and yet the vast majority of them are certainly practising obstetrics—clearly the only instruction they have received up to this point is the two or three months as undergraduates—and obviously this must be far from adequate.

3. *Further education of the general-practitioner obstetrician*

Up until recently the only facilities for further education of the practising general-practitioner obstetrician have been occasional courses of lectures, either for a week or weekend. It is contended that these are most *unsuitable* for practical subjects such as obstetrics.

It was with this in mind that the following ideas for practical refresher courses have been put into effect *in Chelmsford over the last five years.* Already 151 doctors have attended (two at a time only to preserve the tutorial atmosphere with personal teaching) for two weeks each, and 59 doctors have booked ahead as far as 1966. These refresher courses are proving so popular, and the demand for places so great, that it would seem that there is a strong case for establishing such a centre in every two regions of the country at least, and possibly one for each university. For example a *Postgraduate Institute of Obstetrics for general practitioners in a large and busy obstetric unit.*

This department should be designated as a teaching unit so as excellent staff—doctor and midwife—will be attracted to it, particularly those with a teaching vocation. In these departments, resident accommodation, library and tutorial rooms should be provided for the doctors: ultimately research facilities would need to be established. In Chelmsford such an 'institute' was created in the National Health Service hospital (St John's) in 1960 at very little cost to the country, but unfortunately it has inadequate facilities. It is suggested that each postgraduate faculty of every university in the country, might appoint a director of postgraduate obstetrics for general practitioners, and this obstetrician should then be in charge of (1) the postgraduate institute of the university (as described above) and (2) directing refresher teaching in every hospital management committee throughout the region or area of influence of the university—he would visit each hospital management committee area and offer guidance and material assistance to the consultant obstetricians on how they might mount local teaching, day by day. (Table III).

In Chelmsford the local doctors are taught by monthly perinatal conferences, seminars and discussion groups: whereas the doctors attend-

ing the postgraduate school for resident practical work are drawn from all over the United Kingdom and many from abroad, for example from Africa, U.S.A., Australia, India.

TABLE III

THE OBSTETRIC TEACHING AT ST JOHN'S HOSPITAL, CHELMSFORD

General practitioner	*1960*	*1961*	*1962*	*1963*	*1964*	*1965 (so far)*	*Total*
2 weeks post-graduate course ..	5	27	47	41	55	33	208
Seminars (lectures)	65	45	41	21	80	37	289
Monthly perinatal conference ..			20	148	328	180	676
Medical students (London Hospital)	25	36	26	21	21	12	141

4. *Education of the mother*

It is clear that the mothers of the country need educating in an obstetric sense—and probably the most important help that we can give is that they should always accept their doctors' advice. It will be noted that 91 mothers were thought to have died in 1958/60 because they refused advice. If the doctors themselves are better educated, they will undoubtedly help to educate the mothers in the future.[5]

5. *Education of the consultant*

These postgraduate institutes are obviously the places where much of the emphasis should be on obstetric teaching in the future—and not predominantly in the undergraduate teaching hospitals, where the students are taught for so little time. Clearly therefore these are the ideal departments to train the consultants—furthermore, not only are they suitable in that the great majority of the teaching will be conducted in the wards, but also because they will be the larger obstetric departments where the amount of clinical work available to help the prospective consultant to gain his experience will be considerable.

It is worth considering that future obstetric research might be better undertaken in these large, busy teaching units, rather than some of the small undergraduate teaching hospital departments.

Furthermore, in addition to the above considerations, the supply of specially trained consultants may become seriously reduced if the Platt Report is adopted in its entirety, and it is therefore highly desirable to have more in training within the very near future.

Summary

This memorandum serves to illustrate:

1. That the perinatal mortality and morbidity and the maternity

mortality and morbidity in this country are too high.

2. That the postgraduate education of the doctor will drastically reduce these figures now—the Chelmsford system of education is described, and its results prove this point.

3. Medical research will help to investigate genital abnormalities and other unknown conditions which contribute to mortality but any improvement from this can only be expected in the very distant future.

4. That the general-practitioner obstetrician is most anxious to know his subject well, and the only way to achieve this is to afford him better educational facilities—and until these facilities are available to him nobody has a right to criticize his work.

5. That a director of obstetrics for general-practitioner education should be appointed to every university in the country. This person's work should not only include the direction of the teaching in regional institutes of postgraduate obstetrics for general practitioners, but should also include the guidance in the day-to-day refresher education of all obstetricians within the geographical area of the university.

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PERSONAL POINTS OF VIEW

INJECTION THERAPY

Some Cultural Aspects

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THE HYPODERMIC INJECTION IS A well-recognized and well-used method of administering drugs in present-day therapeutic practice. It is such a common procedure that little time may be spent in a busy practice on