THE CHILD WELFARE AND MATERNITY SERVICES*

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I feel deeply sensible of the honour done to me by the invitation to talk today on the child welfare and maternity services. These services have a tripartite structure and their success depends on the close friendly relationships of three different groups. The executive council provides the general medical services and controls the admission to the obstetric list. The local authority administers the maternity and child welfare clinics, the municipal midwives and the health visitors; and the regional hospital board is responsible for the specialist obstetricians and paediatricians. This division of interests and responsibilities is unfortunate, for where active co-operation is lacking, rivalries develop and the service suffers.

Today I hope to give a few glimpses of the subject as seen in my adopted city of Worcester, which is well known for its cricket, races, Sir Edward Elgar, Sir Charles Hastings the founder of the British Medical Association, and its sauce. In this "Faithful City" there is the cathedral, two schools for boys, one founded in the 13th century and the other in the 16th. The Royal Porcelain Works were founded in 1751 by Dr. John Wall, who seems to have been a most energetic general practitioner as, apart from establishing this company, he was an oil painter of no small repute.

The vital statistics, births, deaths, infant and maternal mortality rates, are very close to the national averages. The age group distribution of the population is very close to the national average, and does not vary by more than 0.6 per cent. in any group. Stephen Taylor[1] has commented on the services per patient per year given by general practitioners in different parts of the country. The range is from 7.80 for Wales to 3.84 for the southern region of England; the figure for the Midlands and Worcester is 4.80. The occupations of the Vigornians vary from those of agriculture, to the numerous small factories and industries, with no one industry predominating. These figures show that Worcester is a near average town, and it is reasonable to assume that the pattern of medical life here is fairly representative of that in England and Wales.

General Practitioner Maternity Unit

Before the last war there was only one local authority maternity and child welfare clinic which was old, unsuitable and inconvenient.

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The staff consisted of four health visitors, four midwives and some voluntary workers, with a specialist obstetrician attending twice a month. Most normal cases were conducted at home, or in a nursing home, and the abnormal admitted to a voluntary hospital. Three beds were available at the Poor Law Infirmary for cases with very bad social conditions, but it was not always easy to persuade the mothers to go there, as they had a definite prejudice against having their children born in the workhouse. As a result these beds were not used to full capacity. Only sixteen mothers were admitted in 1938; the others preferred to remain in their unsatisfactory homes. This workhouse was built on a hill, with a railway station on the one side and a cemetery on the other. Even today, at six o'clock in the evening, a small queue of half a dozen foot-weary tramps may be seen at the side door of the " dossy " waiting to be admitted to their own cubicle and locked in for the night.

It was from this rather humble beginning that the present general-practitioner maternity unit of eighteen beds had its birth, and nowadays prejudice is rarely met with, as the workhouse name has disappeared and it is called Shrub Hill Hospital. The responsible authority is the regional hospital board, but the medical officer of health is the administrative officer; a continuation of the old system when the latter was in full charge of the workhouse. Until a short time ago there were two such units with a total of twenty-six general-practitioner beds. Due to reasons which need not be gone into today, one—a fine mansion on the Severn—was closed, resulting in the loss of eight very precious beds and now there is an urgent need to increase the size of the remaining unit, or to open a similar one elsewhere in the city. Admission depends on the home conditions of the patient, and this is decided by the senior health visitor, acting for the medical officer of health. All bad social cases are booked at once, and mothers from reasonable homes are put on a deferred list. Most patients, provided they apply early stand a fair chance of a bed, but because of the limited accommodation some have to be sent to the specialist hospital or confined in an inadequate home. Recent decorations and alterations have been made, and today there is a lift, a labour room, two wards, a nursery, and a staff of four midwives. Last year 459 cases were admitted. When the patient is admitted the practitioner is notified so he may plan his day, and in most of the cases he attends the birth. Both medically and administratively the unit functions well, and the general practitioner/midwife relationship is excellent.

In 1938[2] the district midwives were responsible for most of the 818 births and medical aid was required in one-third of these.

Midwife booked cases declined after the "appointed day"; the numbers fell to 208 in 1949[3] and to 69 in 1954[4]. During this latter year the general practitioner was booked for 196 home confinements and in 56 per cent. of these he was present at the delivery. In 1938, 8 per cent. were admitted to the specialist hospital and in 1954 the percentage was 25. This increase is considerable and is partly due to normal cases being admitted for teaching purposes and some for social reasons. Another factor is the advance in medical knowledge. What was normal in 1938 may be considered abnormal in 1954.

Two years ago there were five district midwives in the city, three working from their own houses and two from a training school for midwives. At this centre two weekly antenatal clinics were held, one of which was staffed by a general practitioner paid on a sessional basis by the health authority. His clinic was run in close association with the pupil midwives and constituted an integral part of their training. During the year eleven trainees were accepted. The question of the training of midwives by general practitioners has often been raised; in Worcester this scheme has been in operation for many years and is a complete success.

Child Welfare

In 1949[3] there were four child welfare clinics having twenty sessions a month, and in 1954[4] the number had increased to seven and the sessions to thirty-two. Although the facilities were considerably improved, total attendances fell by 16 per cent. In 1954 54 per cent. of the children under one year were seen at a clinic; from one to two years the percentage was 45, and from two to five, 11 per cent. During the year my partner and I saw all our patients under two years of age, and 85 per cent. of those between two and five. We are interested in child welfare, and are most anxious that no other authority should do this work which we consider is rightfully ours and is essentially the responsibility of the family doctor. Vaccination is no longer carried out at these centres, immunisation against diphtheria is more often performed by the general practitioner, and I hope in the near future the administration of the B.C.G. and poliomyelitis vaccines will be handed over to the family doctor.

The Cohen report[5] reviewed general practice and showed that all was not well between the health authorities and the practitioners. "In the past, there has, for example, been insufficient co-operation between the general medical practitioners and health

visitors. There were indeed, at an earlier stage, antagonisms because of possible, and sometimes actual, conflicts of influence and of advice between the health visitor and the family doctor." Reference was also made to the agreement between the British Medical Association and the Society of Medical Officers of Health. This agreement states that where, in the opinion of a medical officer, a child requires special investigation (other than an ophthalmic examination) or treatment, the patient should not be sent to a specialist before consulting the child's own doctor, who should be given the opportunity to make the necessary arrangements for the second opinion. The responsibility for general medical care rests with the family doctor. The medical officers in question do not always honour this agreement and consequently there is friction. In order to stop this Gilbertian state of affairs, the report hoped that medical officers of health would try to arrange for better co-operation and take the initiative whenever possible. In Lincolnshire this has been done. The local authority and local medical committee have gone into the problem and arrived at a solution. At first the assistant medical officers objected to losing responsibility for treatment, but they have now accepted the position, and are carrying out their part of the arrangement.

Certainly these local authority clinics were necessary before 1948, but now that there is a comprehensive medical service, and everyone may have a doctor, the need for their continued existence is doubtful. The service they give can be provided as well, if not better, by the family doctor and as long as they exist they tend to drain away patients for whom he is primarily responsible. They are expensive to run, they are a legacy of the past, and are repeating the work of the general practitioner. If these local clinics were closed and all the medical attention which they give was carried out by the family doctors, the extra duties involved for the average Worcester practitioner would be seven items of service a week; a negligible amount. Health visitors instead of sending children to the clinics should send them to the family doctor.

I would like to see the abolition of these clinics and a closer liaison between the medical officer of health, his nursing staff and ancillary workers, and the general practitioners.

Antenatal Care

My partner and I work from a main surgery. Maternity work is shared and we attend some ninety cases a year. The surgery is on the ground floor of a Georgian house on the main road, next to the Eye Infirmary, and there is no lack of accommodation for surgery purposes. Whilst this is admirable in many ways there are

some real disadvantages, such as repairs, decorations, Schedule A, and the new rateable values. The back half of the building is self-contained, and there we hold our daily surgeries. There is a consulting-room, an examination treatment-room, a waiting-room, a records-room and a lavatory. A part-time secretary is employed during surgery hours, to get out the medical cards and do the filing. The front half of the building contains a separate waiting-room, a consulting-room on either side, and an office for a full-time secretary-receptionist. Here we hold the child welfare and antenatal clinics, and there are many advantages in having two consulting-rooms. It allows the mother or child to undress and dress at leisure, and saves time which would otherwise be wasted. One room is used for the routine antenatal examinations, and the other for vaccinations, inoculations, postnatal and general examinations. In the waiting-room the mothers are able to discuss their own maternity problems away from the other patients.

I have found it a distinct advantage to combine the antenatal and child welfare clinics, as so often an expectant mother has a family which she does not wish to leave at home. My partner, on the other hand, prefers to have a separate child welfare clinic.

A good obstetric record card is essential, and for the last two years the one that has the blessing of the Research Committee of the College has been used and this is extremely good. A column of headings has been typed on the right hand side, such as—place of confinement, condition of breasts, nipples, teeth, etc., which is used as an *aide-memoire*; each item being ticked off as it is attended to. These cards are housed in a ring book, which is divided into four sections. The first section is the largest and has the cards of the mothers under eight months pregnant. At the thirty-sixth week the pelvic examination is carried out and then the card is moved to the second section where it remains until delivery. Then to the third section until the postnatal examination. After this it goes to the last section until the executive council pays the fee and then it is removed and filed away.

At the initial examination a complete history is taken and a full physical examination is made, particular attention being paid to the teeth, the breasts, the nipples and the legs. The abdomen is palpated to see if the size of the uterus is consistent with the last menstrual period. No pelvic examination is performed at this visit. Blood pressure is taken, and before the cuff is removed blood is withdrawn for WR, haemoglobin, R.B.C.s, film, Rh. factor, and group. If the patient is found to be Rh. negative the husband's blood is taken. We have direct access to hospital x-ray and pathology departments and the value of such facilities is well known. Twice a week, expectant mothers may be referred to the

laboratory for blood examinations, but, in our practice, we prefer to use the antenatal outfit supplied by the hospital and withdraw a blood sample. This saves time and helps to develop the patient/doctor relationship. The radiology department is available at all times, and if an x-ray of pelvis is required urgently the film is taken at once and the results telephoned the same evening. Unless an up-to-date chest x-ray has been taken, the mother is sent to the chest clinic where a 70mm. camera is in use. All cases have full haematological control throughout the pregnancy and puerperium.

The place of confinement is then discussed. A small percentage wish to be confined at home, but the majority favour an institution. The patient is then given her welfare food form, the Ministry of National Insurance Maternity Benefit Claim form and the necessary leaflets. I find it much simpler to keep a supply of these forms at the surgery, and issue them there, rather than tell the patient where they may be obtained. A specimen of urine is requested at each attendance and arrangements are made to see her monthly until the seventh month, and after that time consultations are fortnightly and then weekly. Some mothers, especially primigravidae may be working, and find it inconvenient to attend the morning clinics. In these cases arrangements are made to see them before the evening surgery.

At subsequent examinations I try to educate mothers to breast feed their babies, and plastic nipple shells or shields are prescribed where indicated. I also explain the Waller technique[6] of breast management, and advise this to be practised daily, so that she will be competent after birth. The physiology of childbirth is discussed, and the patient is invited to ask questions.

Eighty of my last 122 obstetric cases were confined at home or in the unit, and sixty of these deliveries were attended. The average items of antenatal care for each patient was eight, and half of these mothers came to my clinic before the end of the third month. One patient required forceps, a rubella contact received gammaglobulins and two mothers had congenitally abnormal babies. An attempt is made to attend every birth even if it appears all will be normal. This does not take much time, and the results justify the extra energy involved. The patient is examined at the onset of labour, during labour and when fully dilated. When a Rh. negative mother is confined, cord blood is taken for a Coomb's test and haemoglobin estimation in case an exchange transfusion is required.

Four patients left the district before term and nineteen emergencies were sent to hospital with either an abortion or premature labour.

The remaining nineteen cases were non-emergencies and were admitted to the specialist hospital for the following reasons:—

Five social cases could not be admitted to the unit due to insufficient beds; four were sent for therapeutic abortion or sterilization or both; four were toxaemias; two were placenta paevias; one was a breech primigravida; one an elderly multipara and one disproportion electing to have a Caesarean section; one had a positive W.R.

Whenever one of these cases is booked for the hospital I prefer, if possible, to do the antenatal care and the postnatal examination. Twelve of these non-emergencies could have remained in my care until admission. Sometimes close contact is maintained with the patient and there is often no reason why the obstetric care should not be continued until admission. Unfortunately there is no definite agreement about this matter.

Discussion

Numerous reports and papers have been published about the maternity services as seen from different viewpoints, most of these are contradictory and it is almost impossible to get a true picture. Dr. Stephen Hadfield[7] in his *Field Survey of General Practice* said that one-third of the general practitioners disliked midwifery and had discontinued it entirely, or were anxious to cut it down to a minimum. This may be true, but unfortunately their reasons for not practising midwifery are not given. If the age distribution of those engaged in general practice is studied it will be found that one-third are over fifty-five years of age. No doubt some will continue to practise midwifery, but is it not more likely that either a large number have stopped midwifery for health reasons or that there is a younger partner who attends to this side of the practice?

The professional man, especially the medical, has always been a favourite target of the yellow press. Even Shavian wit has not been lacking, and since legal aid has appeared what were previously only words have become the deeds of the court. We may ignore the irresponsible press, but the same cannot be said about the attacks from within our own profession. Collings[8] started the offensive in 1950 and many of his charges can be reasonably explained away; his selection of practices was not representative; he was a colonial; he did not understand our way of life. However, in 1951, The Royal College of Obstetricians and Gynaecologists[9] set up a committee to assess the obstetric service in England and Wales and to study current trends in the balance between hospital and domiciliary confinements, and the parts played by midwives, general practitioners and specialists. The report was published in 1954 and showed that attendances at the antenatal clinics are dropping because of the increased interest of practitioners in their own cases and, in view of this, several of the general-practitioner

obstetricians who were interviewed suggested that these clinics were now unnecessary and should be abolished. Some of the observations of this committee require special attention and here are three extracts:

1. " It is understood that some medical officers of health are unwilling to consider their abolition because they feel that the quality of antenatal care given by their officers is much higher than the average quality provided by general practitioners."
2. " . . . . the fear is generally expressed that the quality of antenatal care provided by the general practitioners is of a lower standard than that provided by the medical officers of the local authority clinics. The minimum amount of antenatal care by general practitioners laid down by the National Health Act is insufficient, but tends to become the maximum the patient is given."
3. " Five of the six midwives thought that the quality of antenatal care had deteriorated. Some said that better antenatal supervision was given at the local authority clinics, and that blood-tests were not so regularly carried out by the general practitioners as they were at the clinics."

This last extract sounds very like Dr. Collings when he said that the few practitioners who continued to dabble in midwifery were mostly considered by midwives and other responsible observers to be a menace. Most of the charges against us are not for not attending the delivery, but for a low standard of antenatal care. These wholesale charges must not go unanswered as they do present a serious indictment. Antenatal care should be, and I believe is, better when performed by the family doctor. He has a personal interest in the family and, unlike the local authority medical officer, he can and in many cases does attend the birth. If this report is examined, it will be found that its conclusions are biased, and are arrived at on very slender evidence. Five medical officers of health are thanked for their information and help. One had never been consulted, and three of them disagreed with the opinions expressed. This report cannot be compared with a similar one published by the same Royal College in 1948.[10]

Recently the South-west Faculty Obstetric Survey Preliminary Report was published in *Research Newsletter* No. 10[11]. *The Medical World*[12] leader-writer has commented on this, and said the results were not entirely reassuring and that " Ergometrine, established as a valuable routine prophylactic against postpartum haemorrhage,

was administered to only 10 per cent. of forceps deliveries and, one assumes, to even fewer normal cases." This is the passage in question. "At the end of the second stage in forceps deliveries, ergometrine was given intravenously in 6%, and intramuscularly in 4%." That is all. Nothing in this preliminary report is said about ergometrine being given in the third stage in forceps cases. This valuable drug might well have been given in the remaining 90 per cent. and in 100 per cent. of normal cases. It is obvious that the report was not read correctly and unjustified criticism made.

Further work should be done and evidence produced to prove that the average general practitioner in this field does not merit the criticism levelled against him by his colleagues, and I suggest our College should conduct a survey of maternity care as given by all its members. Already the Minister of Health has followed the advice of the Guillebaud Committee and set up a committee to review the present organisation of the maternity services and this is welcomed.

REFERENCES

[1]Taylor, Stephen (1954). *Good General Practice.*
[2]M.O.H. Annual Report, Worcester (1938).
[3]M.O.H. Annual Report, Worcester (1949).
[4]M.O.H. Annual Report, Worcester (1954).
[5]Central Health Services Council, Report of the Committee on General Practice within the N.H.S. (1954). H.M. Stationery Office.
[6]Nixon and Hickson (1953). *Guide to Obstetrics in General Practice.*
[7]Hadfield, S. J. (1953). *Brit. med. J.*, **2,** 692.
[8]Collings, J. S. (1950). *Lancet*, **1,** 555.
[9]Report on the Obstetric Service under the N.H.S. 1954. R.C.O.G.
[10]A Survey of Social and Economic Aspects of Pregnancy and Childbirth undertaken by a Joint Committee of the R.C.O.G. and the Population Investigation Committee, 1948.
[11]*Research Newsletter.* College of General Practitioners (1956), **3,** 24.
[12]*Medical World.* Leading Article, April, 1956.

NOTICE

ANNUAL GENERAL MEETING

1956.

The Annual General Meeting, 1956, will be held in the GREAT HALL, BRITISH MEDICAL ASSOCIATION HOUSE, TAVISTOCK SQUARE, LONDON W.C.1, on SATURDAY, NOVEMBER 17, 1956, AT 2.0 P.M.