

**SAVE THE MOTHERS**

# *Save the Mothers*

*A Plea for Measures to Prevent the  
Annual Loss of about 3000 Child-  
bearing Mothers and 20,000 Infant  
Lives in England and Wales and a  
Similar Grievous Wastage in other  
Countries*

by

E. SYLVIA PANKHURST

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ALFRED • A • KNOPF • LONDON

PRINTED IN ENGLAND FOR  
ALFRED A. KNOPF LIMITED BY  
RICHARD CLAY AND SONS LTD.  
BUNGAY SUFFOLK

## PREFACE

THIS book is an urgent plea for a universal, free Maternity Service, and an earnest effort to make plain the great need of mothers and the grievous hardships, risks and suffering encountered by them in pregnancy and childbirth.

For important views on the situation in this country I am indebted to notable compatriots whose names appear in the text. For opinions and information respecting the position abroad I have to thank Professor van Rooy, director of the famous University Maternity Hospital, Amsterdam; my friend Betzy Kjelsberg of the Norwegian Women's Council, and the director of the Clinic of Brandenburg, as well as many foreign Governments and British Consuls and the Governments of the British Dominions and their agents here, who have courteously supplied me with important documents.

The burden of life is too often too hard for the mothers; their need calls to-day for great nation-wide agitations, patient, intensive local effort, individual zeal and care; it makes its appeal to each one of us.

Society has indeed no duty more essential than to provide first-class aid for the creators of its life, who bear in painful travail, and with an enormity of unnecessary agony, those infant new-comers to our world, who, groping unsteadily after primæval experiences, yet hold within them, if they come scathless through the birth, potentialities of achievement beyond our ken.

E. SYLVIA PANKHURST

“UNTIL it is realised that much of the poignant sorrow and suffering caused by misadventure at the time of childbirth is not inevitable and can be lessened, we shall be slow to find the time, money, effort and good will needed to persuade all concerned to combine to overcome the practical difficulties of the problem.”

DAME JANET CAMPBELL, D.B.E., M.D., M.S.  
*Senior Medical Officer for Maternity  
and Child Welfare, Ministry of Health*

# CONTENTS

CHAP.	PAGE
I. THE PRESENT WASTAGE	15
II. THE MOTHER'S CASE	25
III. THE MATERNITY HOSPITAL	37
IV. THE LONG NEGLECT OF MATERNITY	46
V. THE MIDWIFE'S CASE	64
VI. THE HOME HELP	79
VII. ANTE-NATAL CARE	85
VIII. THE SUPREME IMPORTANCE OF LABOUR: DOCTOR <i>v.</i> MIDWIFE: ANTE- <i>v.</i> INTRA-NATAL CARE	93
IX. ABORTION	108
X. THE WAGE-EARNING MOTHER	111
XI. THE UNMARRIED MOTHER AND HER CHILD	115
XII. A NATIONAL MATERNITY SERVICE AND BOUNTY FOR MOTHERHOOD	121
XIII. SOME SCHEMES FOR AN IMPROVED MATERNITY SERVICE	135
By the British Medical Association; the Medical Women's Federation; the Midwives' Joint Committee; Labour Party and Standing Joint Committee of Women's Organisations; Maternal Mortality Departmental Committee.	
XIV. THE CARE OF MATERNITY IN SOME OTHER COUNTRIES	145
Holland, Sweden, Denmark, Norway, France, Germany, Soviet Russia, Latvia, Poland, Ireland, Australia, New Zealand, Canada, Southern Rhodesia, The United States.	

CHAP.		PAGE
XV.	LETTERS ON MATERNITY	
	From George Bernard Shaw	182
	The Right Hon. J. Ramsay Mac- Donald, M.P.	184
	The Right Hon. Arthur Henderson, M.P.	184
	Miss Margaret McMillan	185
	Colonel Mansell Moullin, C.B.E., F.R.C.S.	186
	The Right Hon. Sir John Gilmour, M.P.	186
	R. F. Picken, Medical Officer of Health for Cardiff	186
	Miss E. Simpson, Secretary of the Midwives' Institute	188
	Miss Mabel Liddiard, C.M.B., Matron of the Mothercraft Training Society	188
	Miss Ellen Wilkinson, M.P.	189
	Lady Cynthia Mosley, M.P.	190
	Miss Dorothy Jewson	191
	A Working-class Mother	191
	An East End Mother	192
	Sir Samuel Scott, Chairman of Queen Charlotte's Hospital	193
	A Practising Midwife	194
	Eric Pritchard, M.A., M.D., F.R.C.P.	196
	SOME PUBLIC UTTERANCES ON MATERNAL MORTALITY	
	The Right Hon. Stanley Baldwin, M.P.	199
	The Right Hon. Arthur Greenwood, M.P.	200
	Miss Susan Lawrence, M.P.	200
	F. W. Pethick Lawrence, M.P.	200
	S. G. Moore, M.D., M.R.C.P., D.P.H., Medical Officer of Health for Huddersfield	201

CONTENTS xiii

STATISTICAL APPENDIX

	PAGE
1. MATERNAL MORTALITY IN VARIOUS COUNTRIES	203
2. MATERNAL MORTALITY IN ENGLAND AND WALES, 1911-28	204
3. CAUSES OF MATERNAL DEATH IN ENGLAND AND WALES, 1928	205
4. CAUSES OF STILL-BIRTH IN ENGLAND AND THE UNITED STATES	206
GLOSSARY OF MEDICAL TERMS	207
INDEX	211



# SAVE THE MOTHERS

## CHAPTER ONE

### THE PRESENT WASTAGE

THE heavy loss of mothers in childbirth to-day commands the attention of the entire civilised world. In England and Wales alone more than 39,000 mothers' lives were sacrificed in the birth process during the last ten years.

Whilst the death-rate from all other causes in all civilised countries has shown a great and constant reduction, the maternal death-rate alone has remained practically stationary since the beginning of the century.

To this statement one exception must be made; the rate of still-births, so far as statistics are obtainable, is also apparently stationary; whilst the death-rate of infants under one month of age, and especially under one week, has by no means shared in the great reduction of the infant death-rate during the subsequent eleven months of life, which has occurred almost universally during the last twenty years.

The causes of still-births and of infant deaths in the first days and weeks of life are, in the main, the same causes which lead to maternal deaths and maternal invalidity. Birth injuries are a major cause of still-birth and neo-natal death.

In England and Wales, out of an average of 750,000 births, some 3,000 mothers die annually, approximately one mother losing her life for every 250 babies born. There is an average of three still-births for every hundred live births. In 1928 there were 660,267 births and

2,920 mothers died in childbirth, a mortality rate of 4.42 per 1,000 births, the highest recorded since the revised classification in 1911. In the same year there were 27,580 still-births, a rate of 40 per 1,000 births.

Between 1905 and 1928 the death-rate of infants under one year in England and Wales had fallen from 128 to 65 per 1,000 births; but the death-rate of infants under one month had only varied from between 41 and 31 per 1,000 births in the same period.

The losses in Scotland are higher. In 1928 the mothers' death-rate there was 7.0 per 1,000 births.

Dr. Veitch Clark,<sup>1</sup> the Medical Officer of Health for Manchester, recently pointed out that childbirth, though not a disease, ranks first in this country amongst the killing diseases in mothers of childbearing age. Their risk in childbirth is three times greater than the risk of death from cancer in the population as a whole, two and a half times greater than the general risk from tuberculosis, one and a half times greater than from diseases of the heart, and 27 per cent. greater than the risk of the general population from diseases of the lungs.

Where there is a high rate of mortality there is in all cases a higher rate of invalidity. Sir George Newman, Principal Medical Officer of the Ministry of Health, rightly observes:

“There is no ground for believing that maternal invalidity is substantially declining.”

It is estimated that at least eight times as many mothers as those who die suffer serious illness or injury as a result of childbirth. The causes of maternal illness and death are, of course, in large measure the common causes leading to all forms of illness. Poverty, anxiety and overwork, overcrowding, lack of nourishment and care, all play their part.

<sup>1</sup> Speech at the National Conference on Maternity and Infant Welfare in the Guildhall, July 1928.

"It is, in fact, where the conditions and circumstances are unfavourable that the results are worst,"<sup>1</sup> says Sir George Newman.

This view is supported by an unhappy volume of individual experience, and here and there by the researches of large-scale investigators. Though little statistical evidence on the economic factor in maternal death has been collected, Scotland with its one and two roomed "houses" agglomerated in cheerless barracks, often with a closet on the common stair and a water tap in the passage for the use of several families, its beds in the wall, its hard conditions of women's labour in field and factory, and its inaccessible isles and mountain districts, out-distances England in the scale of demerit. Statistics reveal that the English and Welsh counties and county boroughs where maternal mortality is highest are the textile towns of Lancashire and Yorkshire,<sup>2</sup> where mothers bear the dual burden of factory and household toil; the Welsh mining areas, where housing and sanitation are deplorable and domestic work peculiarly heavy, and the scattered mountainous districts where medical assistance is difficult to obtain at short notice. The textile towns, where maternal mortality is grievously high, are still grave offenders, also, in relation to infant mortality. Wigan in 1923-27, showing an infant mortality of 108 per 1,000 births, is seventh on the black list for maternal mortality. Burnley and Oldham, with an infant death-rate of 107 and 105 per 1,000 births, are sixth and third in the maternal death-rate.

Statistics given by the Medical Officer of Health for Glasgow, in his annual report for the year 1928, in respect of puerperal sepsis in artisan and in well-to-do residential wards of the city, lead him to the conclusion that in the risk of puerperal infection the residential wards possess no great advantage over the artisan; but

<sup>1</sup> Preface to *The Protection of Motherhood*, Ministry of Health, 1927.

<sup>2</sup> See Appendix.

the rate of mortality from the disease, once contracted, was found to be substantially higher in the artisan areas. In Langside, a residential ward, there was a case rate for sepsis of 9.7 per 1,000 births, but every case recovered. There were indeed no maternal deaths from any cause in Langside. The puerperal fever rate for the City was 17.5 cases per 1,000 births, and the death-rate from this cause, 3.8 per 1,000 births.

The report by Dr. Robert Morse Woodbury of an inquiry carried out under the auspices of the United States Department of Labour in 1926 provides most striking evidence. Special investigations into maternal deaths were made in seven cities. The numbers dealt with are large enough to be impressive. It was found that the maternal death-rate was 3.3 per 1,000 births in cases where the father earned more than \$50 dollars, and was so high as 5.3 per 1,000 births where the earnings were less than \$50 dollars. The following table is taken from the report:

Earnings of father.	Confinement.	Deaths of mothers within three months after confinement.	
		No.	Rate per 1,000 births.
Total . . . . .	22,435	111	4.9
Less than \$50 . . . . .	14,810	78	5.3
\$50 and more . . . . .	7,233	24	3.3
Not reported . . . . .	392	9	—

Dr. Woodbury attributed the higher mortality amongst the wives of lower-paid wage-earners to the inferiority of the care, both at home and in hospital, available to their more straitened means. The high death-rate amongst negro mothers emphasises the same point; in cities the coloured maternal mortality being 13.1, as compared with the white 7.4, and in rural areas 9.7, as

compared with the white rate of 5·4. In New York the incidence of septicæmia amongst coloured mothers was three times as high as amongst white.

The Canadian Government Department of Health held an investigation into the causes of 1,262 maternal deaths occurring in 1925-6. Eight thousand medical practitioners were circularised with requests for advice and help, but only 641 replies were received, twenty-four of which emphasised poverty as a cause contributing to the mortality. Forms of inquiry were despatched in relation to each maternal death. Though these were returned by 92 per cent. of physicians concerned, the replies were, in most cases, incomplete.

The question: "By what means might this death have been prevented?" was often unanswered, but when given, the replies were illuminating. In 165 cases it was stated that better financial conditions, more help in the home, relief from excessive work, more sleep and rest would have saved the mother's life. In one case the doctor observed that the woman had no domestic help or anyone to care for her, in two cases she was quite alone when labour came on, the husband being away. Overwork outside the home was given as a contributory cause of death in one case, too frequent pregnancies in 19 cases, generally poor health in 153, anæmia in 44, bad teeth in 30, tuberculosis in 84, heart disease in 95, and venereal disease in 9 cases.

The medical aspect would naturally make the most forcible impression on the doctors, and would be most readily commented upon by them as a part of their professional work, especially since many of them were only called in the last emergency, and had no knowledge of the family circumstances. Therefore it is safe to assume that poverty and overwork played their part in many more fatalities than those noted on the forms.

In 1,089 cases there had been no pre-natal care, either by doctor or midwife; 316 doctors mentioned pre-natal

care and co-operation of the patient with the physician as means which might have prevented the death. Lack of care during the lying-in period was mentioned as the direct cause of death in six cases. In nine cases attended only by untrained midwives the quality of the attendance given was described as "very bad." In two cases it was definitely reported that the untrained midwife was responsible for the mother's death. In 128 cases of death, the doctor was first called when the patient was in labour. In 219 cases no doctor was present at the birth. In 91 cases the doctor was not called until some days after the birth, and in 27 cases only when the patient was dying. In 101 cases no doctor was present, either at the birth or subsequently, the certificate being signed by the parish clergyman or some other person.

The remarks of the Canadian Tuberculosis Association are important:

"The strain of childbirth may not have been enough recognised. . . . Under ordinary conditions where the woman is the housewife, perhaps with duties even outside the home, with one child scarcely on its feet before another is in the mother's arms, with bad housing and perhaps some special cause of worry or discouragement, with the care of fretful and sick children, is it difficult to understand a breaking-down of resistance and a lighting up of even a deeply buried focus (such as may almost be considered universal) into active disease?"

"After early adult life has been reached the cause of tuberculosis is not the tubercle bacillus, but overstrain. An intelligent application of this truth would safeguard the health and life of many an over-burdened childbearing woman."

A list of the causes from which parturient mothers died in England and Wales in 1928 is given in the Appendix. Such a list, without any great material variation, might be compiled for any year in any country

during the century. Septic infection in all countries heads the list, causing a toll of more than eleven hundred deaths; wholly preventable by proper precautions against infection; yet, through neglect of these, it remains the principal cause of maternal mortality in all countries. Other dangers to the mother are the toxæmias of pregnancy, including albuminuria, with its common and terrible manifestation, eclampsia, or puerperal convulsions, which should be treated by pre-natal care and dieting; hæmorrhages before or after delivery, often the cause of fatality and requiring immediate aid; disproportion between the head of the child and the mother's pelvis, mal-presentations (the child lying crossways or otherwise badly placed for delivery), uterine inertia, and many other conditions leading to prolonged and difficult labour, calling for great skill on the part of whoever is aiding the mother in what has become a mortal struggle to give birth. Injuries and shock from difficult labour are a frequent cause of death. All these ills are declared by the experts to be largely preventable.

The origin of puerperal sepsis is the subject of much discussion. Auto- or self-infection by the sufferer's own organism has been spoken of as a possible source, but is generally dismissed as applying if, at all, only to a very small minority of cases. It is generally agreed that infection is most commonly carried to the mother during or after labour, by the hands of an attendant, by the mother's own fingers, by the use of imperfectly sterilised instruments or dressings. The origin of infection has been attributed to ulcers and sores on the body of the infected mother herself, her husband or someone who has waited upon her, or other patients in the same hospital ward, and to contact with persons suffering at the time from an unhealthy condition of the throat and nose from whatever cause.<sup>1</sup> Infection spreads rapidly

<sup>1</sup> The theory of spray, or droplet infection of streptococci, from carrier doctors, nurses and patients on to sterilised hands, instru-

from patient to patient. It may travel with the doctor and midwife from house to house. In maternity institutions any failure to isolate infected patients and disinfect wards, any laxity in permitting attendants to pass from infected patients to others, is punished immediately by devastating results.

Where labour is difficult and prolonged and the mother is exhausted by her travail, where her general physique is poor, she is vulnerable to sepsis, and to all the ills which may follow childbirth. Lack of care, or of judgment in the accoucheur, undue haste, unwise or unskilful operative interference may lead to her death.

The overwhelming importance of the nutrition available to the pregnant woman in relation to her powers of resistance to infection is suggested by the experiments into the anti-infective properties of Vitamin A amongst maternity patients of the Jessop Hospital Sheffield in 1929, carried out by Mellanby and Green.<sup>1</sup> During the two years 1927-28 there had been a mortality amongst certain septic cases of 92 per cent., twenty-two mothers out of twenty-four having died. In 1929 five infected cases were treated with Vitamin A and all recovered, though each of these patients had been precariously ill when the treatment began.

It should be obvious that for pregnant mothers a sufficient and suitable diet should be treated as an essential. The investigators observe:

“The growing animal, whose metabolic rate is relatively much greater than that of the adult, is known to make greater demands on its stores and supplies of Vitamin A than the slow-growing or

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ments and dressings, has been elaborated by Kinloch, Smith and Stephens after investigations in Aberdeen (see Chapter VIII). Bacteriologists, who investigated an outbreak of puerperal sepsis in the Sloane Maternity Hospital, New York City, held the same view.

<sup>1</sup> E. Mellanby, M.D., F.R.C.P., F.R.S., and H. N. Green, M.D., Ch.B., M.Sc., “Vitamin A as an anti-Infective Agent,” *British Medical Journal*, June 1, 1929.



adult animal. It is probable, therefore, that unless her intake of Vitamin A is high, the liver stores in a woman are gradually diminished during pregnancy."

Experiments by Plimmer, Rosedale and Raymond on rats showed that shortage of Vitamin B caused the death of the mother rat in giving birth to her young, and that efficient lactation was only secured by giving from three to five times more of Vitamin B to the mother than was needed for other adult rats.

The following budget of an expectant mother living in East London, and having three children under twelve years, indicates the poor diet available for her, and her inability to provide either for herself or her children the vitamins and calories prescribed by the scientific dietician. The husband's wage is 44s., and 1s. 4d. is stopped for Unemployment Insurance and National Health:

	<i>s.</i>	<i>d.</i>	
Rent . . . . .	12	0	
Insurances . . . . .	1	0	
Coal, 1 cwt. . . . .	2	4	} Some people pay 1s. per week into Coal Club all year round and have in bigger quantities as they want it.
Gas, approx. . . . .	1	6	
Bread, 8d. per day . . . . .	4	0	} (Bread for six days.)
2 lbs. margarine . . . . .	1	0	
Milk 2 pts. per day . . . . .	10	½	
2 tins cond. milk . . . . .	7	0	
Soap and soda . . . . .	7	0	
Flour . . . . .	5	½	
4 lbs. sugar . . . . .	10	0	
1 lb. tea . . . . .	2	0	
Dinners . . . . .	10	6	} Average cost 1s. 3d. per day except Sundays, which would be 2s. 6d. or 3s.
Cheese, 1 lb. . . . .	1	0	
Preserved meats . . . . .	1	0	} For packing man's lunches.
Tallyman or Club . . . . .	1	0	
Loan Club . . . . .	1	0	} From which money can be borrowed for confinement, illness or emergencies paid out at Christmas.
	2	18	

The poor little balance of 1s. is too small indeed for all that remains unmentioned—including the husband's and children's pocket-money. Five pounds a year, at the rate of 2s. a week, is a meagre reserve indeed to provide clothing for the whole family and repairs and replacements of utensils and furnishings; for illness, amusements and emergencies. Obviously it is insufficient; many urgent necessities can only be provided by cutting down the food allowance indicated in the budget on the latter days of the week. This is the habitual proceeding in poor homes, the mother being the first to go short. The budget makes no provision for fruit, though by getting fish when it is cheap, instead of meat, some pence for fruit may be spared. It should be observed that a woman regarded as shiftless may sometimes be one who spends a relatively large proportion of the family income on food and a smaller proportion on clothing than her neighbour, who, with the same income, presents a more prosperous appearance, but who in some cases is more ill-nourished and suffers accordingly.

The National Baby Week Council, in co-operation with the *Daily News*, recently offered prizes to County Boroughs, Boroughs and Urban Districts, showing the greatest percentage reduction in the rate of infant mortality in the first four weeks of life. Inquiries were made of the Medical Officers of Health in the nineteen competing areas to ascertain the influences thought to have led to the reductions obtained. Seven areas ascribed improvement to better midwifery, seventeen to better institutional accommodation, seventeen to attendance at ante-natal clinics, eighteen out of nineteen to the provision by the Local Authority of milk and meals for necessitous expectant mothers.

## CHAPTER TWO

### THE MOTHER'S CASE

THE working-class mother comes to her travail worn with toil. Week by week she has become increasingly unfit for the daily round. Her growing burden weighs heavily upon her, almost unsupportable. Her back aches, her legs swell, her feet burn. Often she is overcome by vomiting and almost frantic with headache; yet there is no rest for her. The needs of the family call her constantly to her tasks, and if, in prostration, she is compelled to neglect them, innumerable resultant discomforts surge up around her, and work accumulates hugely for another day. The children must be sent to school clean and tidy; the washing for them makes a big drain on her energies. When they are all in bed she is darning the great holes in their stockings and patching their clothes. At night she is too tired and discomforted to sleep. She is oppressed by a suffocating sensation of pressure; she has cramp in a limb, her feet and ankles burn, her teeth ache. The cheap flock mattress has gathered into lumps, the slack springs of the old bed sag and creak under her weight. Fearing to waken her husband, she creeps away to a chair. When in the early morning sleep steals over her the children begin to rouse. The youngest already shouts to be taken to her arms. The husband will soon be rising to go to his work.

Even where poverty is not acute, the many claims on the income of a small wage-earner necessitate continual sacrifice of desires and needs. The mother habitually denies herself at every turn to provide the require-

ments of husband and children. In the stress of morning work she commonly gains the habit of eating no breakfast. Her other meals are interrupted by the necessity of feeding the younger children and waiting on the whole family. The habit of self-neglect is scarcely broken in each successive pregnancy. The clamorous needs of the children about her often obscure the claims of the unborn, in spite of her rueful thought for it. Her own needs are unconsidered. Moreover, her appetite is poor, her digestion awry; she has acquired the habit of snatching a slice of bread and a cup of tea after the meal is done. The food she has cooked for the others is nauseant to her. To prepare something special for herself, which might be a little more costly, would seem to her an impossible selfishness. In times of stress it is always she who goes hungry, to leave more food for the breadwinner and the children, taking herself only what meagre scraps may be left. "Mate" he calls her, and truly a mate she is, steadfast as steel, in the enormous multitude of homes.

What more terrible spectacle than the woman who needs to feed for two yet lacks the food for one! Back through the years there flashes on me the vision of a cold grey morning in smoke-ridden Manchester: I in the Oxford Road on my way to school, a woman in a shawl, gauntly emaciated, yet big with child. She stretches a fleshless arm to take from the butcher's board a long bone, utterly meatless. Two well-groomed gentlemen, one with a tall hat, pass me and break into a run, seizing her a few paces from the shop. She turns to them a haggard and tragic face. The butcher runs out, a crowd gathers, a policeman appears.

My knees are trembling, my heart beating to suffocation, the sound of torrential waters roars in my ears. I lean against the wall, feeling in a storm of pity and indignation a poignant regret at being only a helpless little girl. The sad procession, with the policeman's

helmet showing above the heads of the people moves slowly on. . . .

In East London, many years later, I entered a butcher's shop in the Old Ford Road, bent on distributing our suffrage literature to the crowd there. From the darkness outside a woman at the unglazed window, the glare of the gas lamps falling upon her, snatched some scraps of meat. The butcher leapt with a shout, thrust his great girth through the aperture and grasped her wrist. Then, seeing her pregnant, suddenly he released her. "You can take it; that's all right—to *you*." She slipped away, but again he shouted: "Here! some of you! Tell her to wait a minute!" To a clamour of friendly voices the people turned her about and hustled her forward. He rushed to his block, hacked off a great lump of beef and cast it to her: "That'll be better for you!" Tearfully grasping the gift of his rough kindness, again she vanished into the shadows.

"Hard work is the finest thing in the world for a pregnant woman!" runs the complacent old saw, the falsity of which only the woman compelled to practise its harsh precept knows. A young Borough Councillor, who tentatively inquired from her colleagues whether the Medical Officer at the Ante-natal Clinic ought not to have power to supply "home helps" before the confinement was confidently assured that such a provision would be absurd. A few days later she visited a friend whose wife, a University student, was expecting a second child in three weeks time. The woman was already confined to bed and absolutely incapacitated from working by excessively swollen legs. This was a revelation!

On the fourth floor of a block of barrack dwellings is a woman with a face of unutterable suffering. Her eyes

are dull, her limp hair falls neglected. She is dressed in shabby, ungainly clothes. Once she was like those bright, active little girls who climb on her knees, boisterous and unheeding. They too, in their early womanhood, may be faded and worn as she—repellent thought!

In a few days' time she will bring forth another life. She is tortured by a varicose ulcer; her leg terribly swollen, she cannot bear to put her foot to the ground. But there is work to do. She rests her knee upon the seat of a chair, dragging herself on this cumbrous crutch about the room, dressing the children, making the bed and washing up the crockery used at the last meal; and with a slow, painful effort stooping to pick up the odds and ends the little girls have littered about the floor.

At last, unable to endure her pain, she lies on the bed for a brief space, but just as the agony of that leg which should have rest begins to ease, she must be up, for the children are asking for their tea. Stiffing the impatient protest, which for a moment rises to her lips, she crushes the noisiest little youngster in her arms, kissing and praising her in a burst of self-reproachful love. But her leg is tortured; she doubles it under her, pressing all her weight upon it in the attempt to deaden sensation, while she spreads the margarine on the bread.

These two cheerless rooms are a "model dwelling" built by the London County Council. The water tap at the sink, shared by several families, is outside on the landing. A drawer for the coal is in the living-room. Above it the cupboard provided for food has a door of perforated zinc, through which the coal-dust flies in and settles on the food. Everything in the rooms is of the poorest and oldest, save the sewing-machine, by which for years she has mainly supported her household.

She is alone with the children. Her husband, seldom

in work, has a "job outside London" now and sends an occasional dole.

Relief from heavy housework in the later stages of pregnancy would be a boon of inestimable worth to poor mothers; few indeed can obtain it, and many bring about miscarriages and displacements by lifting and reaching. It is the mother herself who prepares the lying-in room; unsparing in her care and anxiety to make the best appearance possible, if her spirit be not already broken. She gives the whole house a special clean down, in view of the strangers who will come in to take control of it when she is incapacitated. Frequently it happens that climbing to dust the top shelf, or hang clean curtains, unwieldy with her burden, she falls from the chair she had perched upon a table or a box to reach thus high. (A step-ladder is a non-essential and therefore absent from poor dwellings.)

During the agony of her labour and the weakness which follows, the mother is torn by anxiety, for the welfare of her children, disturbed by the worries of a small, poor home, overcrowded and lacking innumerable essentials of comfort and privacy, devoid of peace. Often during the painful struggle of the birth crisis, some little child, terrified by the withdrawal of the all-protecting mother care, and the advent of a strange woman, hungry and tired, has hidden itself in poignant misery under her bed of pain, to be found there sleeping at last, when tardy anxiety was aroused on its behalf. A group of little ones, denied admittance to the home during the long hours of travail, sits huddled together on the doorstep in the cold winter evening, far past bed-time, listening in anxious sorrow to the faint, recurrent sound of a mother's groans. Sometimes the toddler youngest in age has contracted a chill, with protracted or even fatal results.

What I know of many little family histories leads

me to the belief that statistics showing the proportion of cases in which the onset of fatal illness in children took place during the mother's confinement would probably reveal a heavy incidence during that period.

As soon as the mother is able to stagger to her legs, and long before she has regained her normal state, she may have to take upon herself the exhausting duties of sick nurse to a child who fell ill during her confinement, in addition to nourishing and caring for the new-born baby and performing single-handed all the exacting labours of a home neglected during her brief period of surrender. Whether she be attended by a midwife, who visits once, or at most twice daily for the ten days following the confinement; or whether it is a doctor and a handy-woman who deliver her, such attention as she receives can rarely be considered nursing and is far indeed from the comfort of the well-to-do woman, with her doctor and trained monthly maternity nurse, holding the C.M.B. certificate. Even during the ten days of the midwife's attendance, the working mother is too often not free from housework. Little children cry about her bed, whimpering to be taken into consoling arms. Toddlers fall, and are hurt, she reaches down to draw them up to her. Elder children come with basins and ingredients, that she may mix the pudding; with bowls of water and soap, that she may wash the napkins of the newly-born, or the knickers of the child of last year's birth. Presently there is a scream; a little girl has scalded her arm, or another child's foot, in pouring from the kettle she boiled that mother might wash the clothes. Even if some neighbour or relative can come in to help with the heavier housework, many tasks inevitably fall to the lot of the lying-in mother and her little ones. If they are able to drag themselves out of bed, mothers often get up during the ten days to do work that is pressing. Many a mother has told me that after



doing so she has washed her feet that the midwife might not know.

The result of this premature toil is prolapse of the womb, varicose ulcers and other ills, mothers who wear a ring to mitigate a displacement and visit the out-patients' departments of hospitals to get it changed, or, shrinking from the presence of students and the hours of waiting which must be faced, prefer to pay what they can ill afford to a private practitioner to get it done; mothers in still worse case, whose condition calls for attention, but who drift on without it, mothers who are lying in the Gynæcological wards, their lives a martyrdom.

"Pardon me for writing to you," a mother pleaded, "but I am in such pain I don't know what I am doing. Well, to begin with, my husband went away on August 6th to the Great War, 1914-18, and my baby was born August 13th. That is three years ago, and having six children I got about too soon, and had to take to my bed for eight weeks, and I have had my leg bad ever since. I have been in bed four weeks, three weeks, and two weeks; but the doctor said that if I don't rest till it is quite well I shall be an invalid all my life—think of me, only thirty-eight years old, not being able to look after my little ones. You know I make everything they wear and knit their socks and vests; I am not a lazy woman. I thought if you could get me away, so I could sit down and rest my leg, I would get better and be a help to everybody, for I am only in the way like I am, a misery to myself and my husband; he has been home for a year now. If it were not for him I think I should go mad. . . . Oh, do your very best for me so that I can get better—a very miserable mother!"

If she decides to go into hospital for the confinement, the mother returns to find her home dirty and

neglected. Utensils, clothing and furniture are broken and destroyed which she had purchased by stinting and sacrifice, and now will find impossible to replace. Often enough a child has fallen ill or been hurt and now requires to be nursed. The children, too young for the task, and the husband returning from work in the evening have been unable to replace her care. All this she foresaw during her absence. She returns to her toil unfit, in her weakness, for the ceaseless round of cooking, washing, scrubbing and mending, as well as the care of her young baby.

The essential importance of household aid during the lying-in period has begun at last, though very slowly, to dawn on the consciousness of society. A few Local Authorities supply "home helps" to attend to the home and children during the absence of the mother, in some areas free, but only in the most necessitous cases. In other areas the patient pays for the help on a scale graduated to the family income. Even when such aid is freely supplied to her, the mother's respite is very brief. The attendances of the home help are in most cases restricted to fourteen days. The Councillors and officials concerned usually insist that this is adequate, that mothers do not desire assistance for a longer period, and indeed are anxious to get the helper out of the house that they may return to their accustomed work. Doubtless they sometimes are; for the presence of a stranger precludes the shifts adopted for economy, which are all the more necessary now that retrenchment must be made for the expenses of the confinement.

Even the woman doctor is apt to adopt the comfortable assumption that the working-class mother so lately risen from her confinement, in spite of her chronic condition of poor health, has, by habit, been rendered immune from suffering under a round of heavy toil, which would tax to the uttermost the energies of the doctor herself at normal times.

A wan-faced mother in a dismal tenement gazed at her puny babe with ineffable tenderness, stroking its fleshless limbs and tiny, claw-like hands. "They are like poor little birds and they are not wanted," she said, and clasped it close in an impulse of pitying love.

Her husband has an abscess on the head and has grown so deaf that he can with difficulty obtain employment. He has had part-time work for a space, but not long enough to gain the maternity benefit. Thus she has not been able to pay a woman to help her during the confinement. Her only aid in the house has been her eldest girl, aged ten. The baby is twelve days old now; the mother has been doing too much, and is feeling faint and weak. The little girl is scrubbing the passage outside while her mother is trying to summon up strength to bathe the baby. A life too hard indeed; yet what a loving companionship enfolds that mother and her daughter, who comes in, her sleeves turned up, and her little red arms glistening from the water and stands to gaze so tenderly on the infant brother.

"She could have done without you!" said the old Scotch woman, nursing her five-days-old grandson: "it's a hard world for you to come into." Its father is in hospital, an incurable case; yet the mother looks brightly upon her baby—her precious burden.

Motherhood is a great mystery. Those who fail to know it have missed an element of the essential fabric of life. Hard and unremitting as her struggle may be, unwilling though the mother was to bow her neck to the yoke of another pregnancy, love and desire for the child grow within her. To every mother—even the poorest, most overburdened—a still-birth is a tragic loss, long regretted.

Again from the old days in Manchester a sad memory rises before me.

We had known since breakfast that Ellen was in

labour. How long she had suffered before we learnt it I do not know; it was characteristic of her that she should trouble us only at the eleventh hour. She had been a friend to us at my father's death. I loved her and heard her sad moans with a poignant agony of grief.

All day she had laboured to bring forth, shut from our sight. It was late in the evening now; the strange woman who had come in to "do" for us and for her had long been gone. Only the sounds of her pain were heard in the quiet house. I wandered about distraught, longing intolerably for the end. The others had gone to a suffrage meeting; I would not go; for me it would have seemed a mockery to be listening to speeches with Ellen in the throes of her struggle. To me she was the embodiment of Womanhood in travail, as well as a dear, devoted friend.

Good Dr. Margaret Bell was in there with her. She came out to tell me, with brief directions, to sterilise for her the instruments and the thread. I carried them to the door in the bowl of boiling water.

At last, as I waited in misery in the dark passage, at call lest anything should be required, the door opened again. The doctor beckoned me in.

The sight of a dead baby, its head hugely long, smote on my eyes.

I knelt by poor Ellen, exhausted, scarcely living it seemed. A sigh, almost inaudible, breathed in my ear: "After all this sad work!"

In the homes of most squalid poverty the heart leaps at the loving smiles between mother and babe. Toothless and hairless still, the infant gurgles its mirthful happiness as it springs to those frail arms; her wan face lights as she dandles its chubby form.

Researches by the New York State Department of Public Health showed that though the infant death-rate as a whole is relatively low, the mortality in the

first year of life amongst children whose mothers died at birth was 50 per cent.<sup>1</sup>

We stumbled from the sunshine and the cloudless sky—the wide expanse of the Cotswolds, the purple pansies and the rough weeds and dandelions of the wild garden—into the quiet shade of the wooden house.

A young woman lay dead there with folded arms, stone-white and still.

We left her in the silent mystery of her fleeting state, memories of her gay gentleness floating about us, gripped by the anguished thought: "She need not have died."

They took us across the fields to the puling infant, a forlorn little motherless waif, dandled in someone's arms, too prematurely a centre of interest to a throng.

The story of her last day burdened our mind. Late on the night before she died she had made coffee for her husband, and an hour or so earlier had climbed the ladder at the bungalow he was building. Her talk had been of dreams for a life changed by motherhood and the advent by inheritance of a little fortune.

Yet she had died in childbirth.

Some time in the small hours of her last day she had left a sleeping husband's bed and crept into that of a woman friend. At seven or so the friend roused up the husband. He cooked himself a rasher and sought the midwife engaged for the confinement—"a natural process, not to be dreaded by any healthy woman!"

At two the child was born. At four, the placenta being undelivered, the midwife, according to her rules, called for a doctor. A messenger went hastening to telephone. Caught on his rounds, the doctor arrived not fully equipped. . . . He telephoned for a colleague. Delay followed delay. . . . Her life ebbed out. . . .

<sup>1</sup> *Health News*, New York State Department of Health, Albany, Feb. 4, 1924.

“Exhaustion and childbirth shock,” so ran the Death Certificate.

The husband, by doctor’s instructions, buried the placenta in the garden, believing it a tumour—so Fate mixes her impish ironies with sad tragedies.

The child remained.

. . . . .

My little son nestled his rosy face against my breast.

The doctor stood beside me:

“If you had not come into the home when you did, baby could not have been born.”

The words came to me as a challenge:

“Seek to obtain for others the care you had!”

## CHAPTER THREE

### THE MATERNITY HOSPITAL

THE average working-class home is too small, too crowded, too poorly furnished to be suitable for the confinement. On an inquiry being held by the Medical Officer of Health for Manchester into the domestic circumstances under which children are born in that city, it was revealed that in 57 per cent. of the houses occupied by one family, and in 94 per cent. of the houses occupied by two families, privacy for the confinement was only possible if some of the inmates were turned out of the house. Yet Manchester is not so badly served in the matter of housing accommodation as many other cities. Conditions in Scotland and many English towns are much worse. A mother of ten children confined in a Lanarkshire nursing home declared: "This is a right holiday for me!"

Everyone knows, but none so well as the mothers who live and work in them, the crowded little dwellings of the poorer working class, with one, two, or three tiny rooms. The largest front room is the repository of the mother's treasures, the furnishings of a parlour she got when she was married. A parlour no longer possible, it serves as bedroom for the parents, the baby, and if need be, for a child or two. Its windows open directly on to the dust and noises of the street, for no inch of ground or railing divides the house from the pavement, where pedestrians pass, and children play and shout with their shrill voices like a shoal of chattering gulls. This is the only place available for the confinement.

In one such home, repeating a million of its type, the

kitchen barely leaves passage between the table where meals are eaten, the dresser and the stove; the scullery is so tiny that it scarcely permits the mother to do her washing. In a small back room two girls, one of them tubercular, occupy one small bed; another wedged against it, and blocking up the fireplace, holds the three boys. A press for the clothes allows only just room for the girls to slip past to their bed. The mother has to crawl under the beds to sweep the floor. Having regard to the circumstances, one is amazed that the place is so comparatively clean. The baby sleeps with the parents in the remaining room, which serves also as sick-room when one of the children is ill, as often happens. Then the mother arranges what her husband calls the "rag time" mattress on two chairs for the sufferer.

Crowded as they are, for the majority of mothers, confinement at home is the only alternative.

Dame Janet Campbell in 1927 estimated that existing maternity institutions in England and Wales provide accommodation for 50,000 out of the 750,000 mothers giving birth to children annually.

Should the institutions keep their patients for a longer period, both before and after the confinement, than at present, as I claim is necessary, the number of women who could be delivered in existing institutions would be appreciably reduced. Actually the institutions known to the Ministry of Health in 1927 provided 2,290 beds for the whole of England and Wales,<sup>1</sup> and in the same year there were upwards of 650,000 births. Even for abnormal cases, such accommodation as exists is in many cases hedged around by restrictions. To the famous Queen Charlotte's Hospital patients are only admitted by letters from governors and subscribers. The average patient, having no acquaintance amongst these persons, must write a begging letter to one or

<sup>1</sup> Under the Midwives and Maternity Act, 1926, all maternity institutions must be registered and are subject to inspection by the Local Supervising Authority.



more of the names, selected at random, from the list which may be seen or purchased at the hospital. The average self-respecting woman does not care to do this, even if assured that five or six letters would certainly produce the desired response. The Royal Free Hospital as a rule only takes first confinements and complicated cases, a procedure followed by several other institutions.

Even for women to whom hospital treatment and surgical assistance are imperative there is in many districts an acute shortage of accommodation.

“Until maternity beds are available for women in all districts, lives will continue to be lost for lack of obstetric facilities, and medical practitioners will not acquire the habit of promptly sending to hospital patients in need of major operative midwifery treatment.”<sup>1</sup>

Even were institutional accommodation available to all mothers, many would refuse it, in fear of loneliness, reluctance to be amongst strangers at such a time and dread of hospital surroundings; above all from anxiety for the welfare of their young children, having no reliable person to leave in charge of them. Many mothers, too, are deterred by the cruel rule, common to most of such institutions, that patients may not be admitted until in labour. Women shrink from the prospect of a journey during their travail. They are affected by premonitions of being confined on the way, or otherwise taken unawares. The eleventh-hour remove to the institution adds immeasurably to the nervous tension inevitable, especially in the case of a first birth. Instead of using to the fullest advantage the primary labour and husbanding her energies for the final stages, the mother is making her preparations to depart, and travelling huddled up in her pains in a cab or a train, perhaps even in a bus, terrified, probably vomiting.

<sup>1</sup> Dame Janet Campbell, *Protection of Motherhood*, Ministry of Health.

Arriving thus in strange surroundings amongst people wholly unknown to her she is ill-prepared for her ordeal. If there is any abnormality such as the early rupture of the membranes (the "breaking of the waters"), an occurrence much more common than is generally realised, the journey may have serious consequences. The matron of a London nursing home told me of a young wife who came up by train to the home with her mother under these circumstances, and whose child, lacking thus the natural protection, was gravely injured.

Miscalculations occasionally happen. A young mother living near to me during the years I spent in the Old Ford Road, Bow, was told on arrival at the lying-in home that she had come too soon; but she gave birth to her child in a cab on the way home. A mother I know living in the country, on being seized with what she believed to be the birth pains, was driven six miles over rough country roads to a maternity home. She was sent back only to return a day or two later. The worry and strain of such experiences should and could be avoided.

Even the cat seeks a secluded bed some days at least before the advent of her kittens, and decent people are always careful to make a cosy nest for her in advance.

The Royal Free Hospital supplies an ambulance without charge to patients whose labour commences between 11 p.m. and 8 a.m., but most institutions make no such provision. Ambulances should be provided by all maternity institutions during night and day.

The Women's Hospital attached to the Amsterdam University admits its patients, as a matter of routine, two weeks before the confinement, earlier if any abnormality presents itself. An ambulatory clinic keeps the mothers under its care throughout their pregnancy, seeing them once a week. If any abnormality, such as albuminuria or hæmorrhage, occurs the woman is at

once taken into hospital. The mothers remain under care of the ambulatory clinic on discharge from hospital after the birth. Home helps are supplied at a low charge whilst the mother is in hospital or arrangements are made to board out the children.

Admitting their patients at the last moment, maternity institutions in this country usually discharge them too soon.

Professor Louise McIlroy of the Royal Free Hospital, lecturing at the National Conference on Infant Welfare in 1928,<sup>1</sup> observed that a maternity patient sometimes appeared perfectly well on leaving the hospital "on the eighth or tenth day"; but "on her return for examination two or three weeks later, the presence of a displacement can be detected." The doctor may be satisfied that the displacement was already present when the patient left the hospital; the mother, who knows how she feels after the confinement, will say the trouble arose later, because she had got about too soon and overtaxed her strength.

Mothers are not fit to return to their household duties for many weeks after the birth; the puerperium should be recognised as lasting for six weeks, whilst for a considerably longer period care should be exercised.

If every mother were assured of three or four weeks' nursing care and medical supervision, either in her own home or in a maternity institution, and a month in a convalescent home, the present appalling post-child-birth invalidity would be immediately reduced.

Even this period would be insufficient in some cases. Provision should be made insuring the continuation of institutional or domiciliary care until both mother and child are fully restored to normal health and breast-feeding is established.

More than one maternity nurse has spontaneously suggested to me, as a result of her experience, that it

<sup>1</sup> Association of Infant Welfare and Maternity Centres, 117 Piccadilly, London, W.1.

should be made illegal for maternity institutions to discharge their patients until the baby has surpassed its birth weight and the umbilicus is in a satisfactory condition. These are but two of many indications upon which discharge from nursing and medical attention should depend.

Unfortunately a substantial proportion of maternity institutions leave much to be desired in construction, still more in management. Perusal of Government reports of the epidemics and fatalities which have occurred in some of them is apt to arouse such consternation as to make the reader exceedingly chary of recommending institutional treatment to any expectant mother.

Sir George Newman<sup>1</sup> reported in 1929 that in a Maternity Home of only ten beds six fatal cases of puerperal fever occurred, the cause of the illness not being diagnosed until three patients had died, one was moribund and two were seriously ill. The Medical Officer to the Home, and even the consultant, treated the second, third, fourth and fifth cases as influenza. The wards were gravely overcrowded and there was no effective isolation, or disinfection. Four of the women had been normally delivered. In this Home, during the preceding six months, there had been many cases of pyrexia amongst the mothers. Pemphigus had broken out amongst the infants, and when, after the first few cases had been isolated, the outbreak was not immediately checked, no attempt had been made to keep the infants apart.

In another small home of ten beds, nine patients developed puerperal fever within six weeks. The first four cases were not recognised as infective and two other cases occurred before the wards were closed to new patients. Four further cases developed and four patients died.

<sup>1</sup> State of the Public Health, 1929.

## THE MATERNITY HOSPITAL 43

Dr. Janet Campbell reports the occurrence of seven deaths from puerperal sepsis in a small hospital for women. The sufferers had not been isolated. The same nurses had been allowed to nurse the infected and those who were still immune. In another home, where three deaths occurred, there had been no adequate disinfection and the second victim had been put into the bed from which the first had been taken the previous day. In yet another home there were three deaths, and other cases of infection. The first patient left the institution alive, but was discharged with a swinging temperature and a torn perineum, from which the stitches had given way.

The report of the Medical Officer of Health for Glasgow for the year 1908 reveals an appallingly high rate of puerperal sepsis in the maternity and parish hospitals of that city, and a still more grievous case mortality in some of them.

Here is the very dark record:

### PUERPERAL SEPSIS CASES AND DEATHS IN CERTAIN GLASGOW HOSPITALS AND IN THE WHOLE OF GLASGOW DURING THE YEAR 1928.

In Hospital.	Births.	Total Cases.	Cases per 1000 Births.	Deaths.	Deaths per 1000 Births.	Case Mortality per cent.
Maternity Hospital (indoor) . . . . .	2,655	70	26.4	21	7.9	30.0
Govan Cottage Hospital . . . . .	260	8	30.8	1	3.8	12.5
Parish Hospitals:—						
Duke Street . . . . .	286	4	14.0	3	10.5	75.0
Oakbank . . . . .	241	4	16.6	1	4.1	25.0
Stobhill . . . . .	649	36	55.5	11	16.9	30.6
Lock Hospital . . . . .	67	2	29.9	—	—	—
All Glasgow, at home and in Hospitals . . . . .	25,045	414	16.5	96	3.8	23.2

It will be seen that with one exception the mortality rate in institutions is very much higher than in Glasgow as a whole.

Even allowing for the fact that the hospitals admit a certain number of patients who are already ill, the heavy case rate and the very grievous case mortality rate in these institutions gives cause for inquiry, if not for censure. That the Duke Street Parish Hospital should have a case mortality of 75 per cent., that there should have been eleven deaths from sepsis at Stobhill, whilst there were only two cases, both of whom recovered, at the Lock Hospital, where a much higher rate of sepsis and of mortality might have been feared, is a most striking and unpleasant fact. One is compelled to ask whether the aseptic precautions observed as a matter of routine in hospitals for venereal disease, for the protection of the doctors and staff, as well as for the well-being of the patients, provide the reason for the lower incidence and more successful treatment of sepsis in the Lock Hospital. The mothers who give birth to children in the parish hospitals are doubtless in most cases wretchedly poor, miserably debilitated; their resistance to disease has been worn down by underfeeding and hard circumstances. Even so a maternal death-rate of 16 per thousand births and a case mortality of 75 per cent. from puerperal fever ought to receive most searching investigation.

The sad fact cannot be too strongly emphasised that many a healthy woman enters a maternity institution and delivers her child in the course of an absolutely normal labour, but is infected through mismanagement in the institution, and dies of puerperal fever. Mr. T. L. Paget, Inspector of Maternity Hospitals to the New Zealand Government, reported in 1929 that in 155 cases of puerperal sepsis in such institutions delivery of the infant had been spontaneous in 100 cases, artificial in 55; whilst in 154 cases of puerperal sepsis delivery of

## THE MATERNITY HOSPITAL 45

the placenta had been spontaneous in 129, and manual in 25 cases. Thus infection is by no means dependent upon trauma caused by the use of the forceps.

Dr. Parlane Kinloch, of the Department of Health for Scotland, writes to me clearly:

“Much of this sepsis in the maternity hospitals is due to bad administration and bad technique. . . . The experience, however, is that once the streptococci causing puerperal fever gain epidemic activity even the most careful surgical technique will fail to prevent the spread of infection. . . . Under such circumstances the cubicle isolation of patients and masking of operatives would appear to be necessary to control infection.”

Separate rooms for maternity patients, complete isolation of all infected cases and the rule, rigorously enforced, that no nurse or doctor who has attended an infected case shall approach a healthy lying-in patient, are essential to the proper conduct of a maternity institution. Without such safeguards no mother should trust herself within its doors.

## CHAPTER FOUR

### THE LONG NEGLECT OF MATERNITY

“OBSTETRICS,” says Dr. Eardley Holland,<sup>1</sup> “is the Cinderella of medicine!”

Dr. Comyns Berkeley recently observed:

“It has been handed down through generations of hospital physicians and surgeons that midwifery is of very little importance and that childbirth, being a natural process, can be left to look after itself. As a matter of fact in the past the obstetric physician has been the butt of his colleagues, on whom they have expended their poor wit, if such it could be called.”<sup>2</sup>

Though seldom if ever mentioned in the height of the Women’s Suffrage campaigns, this contemptuous neglect of the mother’s needs and her all-important function was as grievous an injury to women as any they suffered in the dark period of their political and social subjection.

The extraordinary revelations of reckless ignorance and woeful neglect by medical practitioners towards mothers in childbirth, which are made by obstetric specialists, Medical Officers of Health and Government Reports would excite the gravest public indignation, were they discussed on platforms and in newspapers with the attention devoted to other matters.

<sup>1</sup> *Causation of Fœtal Death*, Eardley Holland, M.D., F.R.C.S., F.R.S.P., H.M. Stationery Office, 1922.

<sup>2</sup> Report of Conference on Maternity and Child Welfare, 117 Piccadilly, London, W.1.



Dame Janet Campbell, in her *Maternal Mortality*,<sup>1</sup> gave an account of five confinements, which in cold brief terms sets forth the amazing cruelty of which poor mothers are sometimes victims. I reproduce it here because, coming from an official source, it is apt to carry more conviction than the graphic histories of their suffering the mothers are themselves able to supply:

*"A Midwife's case:* Doctor called at 9 p.m., August 18th. Baby had hydrocephalus. The doctor performed craniotomy and then further reduced the size of the head with ordinary midwifery forceps, the child being delivered at 11.40 p.m. The doctor did not again call until sent for by the midwife on the 24th. By that time the lochia was offensive, the pulse was rapid, the temperature raised. He merely ordered medicine. He called again on the following day, but the patient died at 4.30 p.m.

"It is perhaps worth noting that the doctor sent in his claim for attendance under the Midwives Act on August 20th, apparently indicating that he did not propose to visit his patient again."

*"A Midwife's case:* When called she found the infant's hand in the vagina and most of the liquor amnii gone. She therefore called a doctor, who succeeded in replacing the hand without an anæsthetic. After two hours the third attempt at forceps extraction succeeded. The perineum was torn into the rectum. Two stitches were put in, which afterwards broke away. On the third day a black mass presented in the vagina which was thought to be either a polypus or the inverted uterus. Efforts to replace this failed, but the woman was not sent into the Infirmary until two days afterwards. She developed puerperal fever and died."

<sup>1</sup> Ministry of Health, 1924.

*"A Midwife's case:* Twins, the second one being a breech presentation. A doctor was called in who did not remove his coat or wash his hands, but dipped one hand into a bowl of antiseptic lotion which the midwife gave him and then introduced this hand into the uterus to bring down a leg. The patient had postpartum hæmorrhage, and she subsequently contracted puerperal fever."

*"A Doctor's case:* Delivered on August 26th in a lying-in home. Patient had a raised temperature, but received no special treatment and left the home on September 8th with a temperature of 100°. She was shortly afterwards admitted to a Cottage Hospital, where she died on September 14th, being attended by the same doctor who delivered her. He certified death as due to toxæmia from retained placenta, postpartum hæmorrhage, but had given no special treatment for this condition. This doctor afterwards met the keeper of the Nursing Home by chance and remarked that it would be 'just as well to have the patient's room disinfected.'"

*"A Midwife's case:* She diagnosed transverse presentation at 8.45 a.m., and sent for a doctor, who agreed with the diagnosis, advised admission to hospital and gave a note for the resident Medical Officer. The case was refused at the hospital as there were 'no beds,' and the woman was sent to the workhouse. She reached there at 2.30 p.m., and was not seen by a doctor until 7 p.m., having had no treatment or relief during the whole day. Both mother and child died."

Ignorance and neglect have too often gone hand in hand in the treatment of childbirth. The community has largely ignored it, hospitals have been lacking, the physicians ill-taught, the midwife until recently un-

trained. Whilst the poor mother has too often been the victim of neglect or undue haste, the rich mother has sometimes been exploited by the obstetrician-gynæcologist, who, as Eardley Holland has it:

“Has become enamoured of gynæcological surgery that he is taking less and less interest in the fundamentals of his more arduous, less brilliant, but more important branch of his art.”

Jellett's pages<sup>1</sup> teem with accounts of rash and incompetent methods of instrumental delivery by general practitioners, as well as by self-styled specialists, who, for excessively high fees, attempt to improve on natural methods. He describes the reasonless resort to Cæsaræan section, craniotomy and premature induction of labour, accompanied, in the hands of such butchers, by a maternal mortality of outrageous proportions, rising indeed to 50 per cent. He tells of serious or fatal injury to the head of the infant, ruthlessly dragged through maternal passages still unprepared to make way for it, by madmen who turn a normal presentation into a breech, or even a foot presentation, and tear the child from the womb, to its own and its mother's permanent injury, many hours before it should have been born.

Dr. Eardley Holland<sup>2</sup> declares that more than 50 per cent. of still-born children might be saved by efficient ante- and intra-natal care, particularly the latter, and that a considerable proportion are killed by injury to the head through applying the forceps to the wrong diameter of the skull, or the use of excessive force:

“If the forceps is responsible for the saving of many fœtuses, it is also responsible for the unnecessary death or injury of many others. It is used too often and on the flimsiest indications.”

<sup>1</sup> *Cause and Prevention of Maternal Mortality*, published by A. J. Churchill, London, 1929.

<sup>2</sup> *Causation of Fœtal Death*, Ministry of Health, 1922.

Jellett estimates that in only 6 per cent. of births is the use of the forceps advisable, but complains that in thirteen New Zealand Hospitals it is used in more than 30 per cent. of cases. "Only the gynæcologist realises," says Professor Johnstone, "how many of his hospital beds are occupied with the so-called 'successful' instrumental cases of five, ten, or even twenty years ago."

Whilst septic infection following all surgical operations unconnected with childbirth has been most strikingly reduced since the introduction of anti-sepsis and asepsis, the septic infection resulting from childbirth has scarcely diminished. Indeed amongst all the departments of medicine there is none wherein illness and death, which could by proper care have been prevented, is so lamentably great as in midwifery. Dr. Comyns Berkeley and others have urged that:

"Parturition is really an operation often of a major character with Nature as the surgeon."

Yet the aseptic precautions employed in the smallest surgical operation are disregarded. Henry Jellett, Obstetric Specialist to the New Zealand Government, late Master of the famous Rotunda Maternity Hospital in Dublin and Examiner in Obstetrics and Gynæcology to Manchester and other universities, declares that "aseptic technique as usually carried out in obstetric practice is worthless."<sup>1</sup> He protests against the "ludicrous" situation of the medical practitioner, who in the morning removes tonsils with the strictest aseptic ritual, and in the evening removes a placenta with none. He emphasises what the high incidence of sepsis

<sup>1</sup> University College sets an example by providing sterile equipment for its students when attending maternity out-patients, including sterile equipment, gown, gloves and drappings, etc. for the patient to train the student to carry out a complete aseptic and anti-aseptic technique, not only in hospital, but in the patient's home.

amongst mothers has taught all who have considered the question that:

“The genital tract after labour provides an excellent site for bacterial growth, and the uterine cavity, and especially the placental site, furnishes a more open port for entrance into the blood or lymphatic system than any ordinary traumatic or operation wound.”

Professor Beckwith Whitehouse recently declared<sup>1</sup> that in a “high-class London Nursing Home” the following incidents occurred within one month: refusal of doctor to have obstetrical forceps boiled, refusal to wear a sterilised gown whilst conducting labour, the placing of sterilised instruments on an unsterilised area, the use of silkworm gut from a box without sterilisation.

Jellett comments:

“Anyone who knowingly and unnecessarily does these things should be tried for manslaughter if his patient dies of sepsis.”

To the lay mind it would appear unnecessary to await a fatal sequel to malpractices. One may venture to suggest that the British Medical Association might be better employed in adopting disciplinary action towards such offenders than in striking Dr. Axham off its rolls for acting as anæsthetist to the famous manipulative surgeon, Sir Herbert Barker. Jellett further complains that many practitioners, with no other title to special knowledge save a mere post-graduate course, style themselves “specialists” in midwifery. “The practice,” he says, “is lawful though inexpedient.” This too, if it constitutes the serious abuse suggested by Jellett, is an appropriate subject for the intervention of the British

<sup>1</sup> *British Medical Journal*, February 4, 1928, Supplement, p. 34.

Medical Association to maintain professional standards. I was interested to observe in an address by Dr. Comyns Berkeley in 1929, a suggestion that to insure efficient medical aid in midwifery, a panel should be set up from which the midwife would be compelled to select, instead of permitting her to choose any doctor she pleases, as at present. This would be a somewhat tortuous method of eliminating the inefficient practitioner, especially as Dr. Berkeley did not propose to enforce it where the patient has already a family doctor. In the interests of its members, the British Medical Association uttered a plaint to the Select Committee on the training of midwives, that midwives send for a doctor with whom they have made some special arrangement instead of to the patient's own doctor. In such collusion the interests of the patient are most likely to suffer.

The insufficiency of the training in obstetrics afforded by the medical schools and the small attention to midwifery exacted from medical students is now widely deplored by those members of the profession whose concern is excited by the tragic losses and grievous suffering resulting amongst mothers. In several countries midwifery education is superior to that given in Britain, or indeed in any part of the British Empire. In Holland and in the Scandinavian countries the training is particularly good, and a considerable number of highly efficient obstetric experts are available. Taking the figures for these countries together, the rate of maternal mortality is 2.53 per 1,000 births, whilst the rate for the British Empire (including England and Wales, Scotland and New Zealand, and Australia) is 4.22 per 1,000 births.<sup>1</sup>

In 1922 the General Medical Council for Great Britain, which has power only to recommend, adopted

<sup>1</sup> Statistics given by Jellett in the report of the Director-General of Health for New Zealand, 1929.

Resolutions for improved obstetrical training of medical students. These have not yet been fully carried out in all medical schools, but even at the best the new curriculum fails to satisfy obstetrical specialists. Dame Janet Campbell says:

“The requirements need still further strengthening and expansion if the student is to be properly trained.”

Even under the new curriculum, thus discounted, it was only suggested that the student should receive instruction in gynæcology and midwifery during at least two terms, theory and practice in all the special diseases of women, as well as midwifery, including labour, ante-natal and post-natal treatment, and infant hygiene being crammed into this brief period. Three months out of the six should be spent in obstetrical hospital practice “under the supervision of a competent officer.” In one month out of the three the student should perform the duties of intern student in a lying-in hospital or ward, to the satisfaction of his teacher. He must present a certificate showing that he has been in attendance during at least twenty labours in hospital or elsewhere, and must make the necessary examinations. He should not undertake the delivery of external patients till he has delivered at least five women in hospital. If no examinations happen to be necessary in the cases he watches he will receive no experience in making examinations. The person who conducts the labours he watches, and from whom he learns the methods he will pursue in his own practice, may be a mere midwife, and the same midwife in each case, whilst the certifying officer who signs his certificate may also be a midwife.

In Holland the medical student takes a six-years course of nine months per annum. In his second year he has two hours' instruction a week in midwifery, not

from a midwife but from the professor; in his third year three hours weekly; in his fourth year ten hours weekly, and must pass a theoretical examination in midwifery. In his fifth and sixth years he gets eight hours' instruction weekly in practical midwifery, six weeks' dressership in the University Midwifery Hospital, during two weeks of which he is in residence. He must act as extern accoucheur for one month and must conduct forty labours under adequate supervision. In the Women's Hospital of Amsterdam University, the number of teaching hours given to obstetrics equals those given to general surgery.

The young English doctor, having been taught merely enough to pass an examination which made little or no demand on his practical knowledge, enters upon his practice poorly equipped for midwifery. On meeting a serious surgical or medical emergency in any other branch of his work he can generally look with confidence for aid to his seniors in the profession, and a hospital bed for his patient is almost certain to be available. In midwifery it is otherwise. In numbers of cases no hospital bed can be obtained, and even if it could the condition of the mother is perhaps too critical to permit of her being moved. In all probability, no obstetric specialist is obtainable, the neighbouring general practitioners are unskilled in obstetric complications. Midwifery is unpopular with them, they have no desire to come, and the patient is unable to pay. Faced with an emergency critically menacing the life of both mother and infant, the inexperienced young doctor is obliged to struggle with difficult cases of placenta prævia, accidental hæmorrhage and transverse presentation, operating under conditions no surgeon would accept, often without even a moderately good light or sufficient clean hot water, sometimes in insanitary surroundings and without even the possibility of pulling the bed out into the room to get at the patient more easily.



For the prolonged and difficult work involved in midwifery, Jellett protests that "the fee is absurd." He adds:

"It is the vital interest of the medical practitioner to be freed from the body and soul destroying business of an excessive midwifery practice."

In the hope of becoming thereby the family physician for all ailments, the medical practitioner has often been willing to attend confinements whilst building his connection, only to refuse all midwifery engagements as soon as fortune has enabled him to do so with impunity. Many a working mother with little to offer in the way of emoluments has been met by the family doctor's refusal to attend her in childbirth, or perhaps with a refusal to do so unless the expected infant will arrange to be born during the day!

When my mother was overcome by hæmorrhage after the birth of her youngest son, our nurse in her cap and apron, running from one doctor's house to another, was four times received with the rebuff—"The doctor does not take maternity cases now." This was before the common use of the telephone.

Very common even to-day are the complaints of mothers that the doctor who attended them in childbirth did not advise on the care of the breast which developed an abscess, discounted or failed to observe a displacement or an injury to the mother, did not notice, or failed to pay attention when it was pointed out to him that this or that was wrong with the infant, gave no advice on its feeding.

Owing to the long indifference towards maternity, of Governments and of the medical profession, and by reason also of the poverty of mothers, a large proportion of women are attended in their confinements, not by a qualified medical practitioner, but by a midwife alone. Until the State registration of these women,

under the Midwives Act of 1902, the untrained handy-woman predominated in midwifery. Even now some of the untrained *bona fide* midwives who were registered at that time remain, and a much larger number of untrained and unregistered women are practising under the protection and encouragement of members of the medical profession.

Dr. Janet Campbell, in her report of Maternal Mortality published by the Ministry of Health in 1924, gave the following figures respecting the proportion of trained and untrained midwives in certain rural and industrial areas where maternal mortality is high:

	Registered Midwives.	
	Trained.	Untrained.
County :		
Breconshire . . . . .	58	30
Montgomeryshire . . . . .	34	12
Pembrokeshire . . . . .	66	26
Westmoreland . . . . .	19	6
Cumberland . . . . .	95	10
Town :		
Halifax . . . . .	20	7
Blackpool . . . . .	18	8
Bury . . . . .	9	7
Rochdale . . . . .	21	10
Oldham . . . . .	26	12
Blackburn . . . . .	32	11

The above figures do not include the untrained and unregistered handy-woman, who works ostensibly under the doctor.

In Scotland the midwife, who, though untrained, is nevertheless registered and permitted to deliver patients unaided, is more common than in this country; for it was only in 1915 that the State Registration of Midwives was adopted there; and, as in England and

Wales, untrained midwives then in *bona fide* practice were placed on the register. The 1928 Report of the Medical Officer of Health for Glasgow shows that amongst the midwives then practising in that city, 181 were entitled to registration by examination, and 108 were untrained *bona fide* midwives.

Under the Midwives Act of 1926 any person other than a registered midwife who attends a woman in childbirth, save under the personal supervision of a duly qualified medical practitioner, or "in case of sudden or urgent necessity," is liable to a fine of £10. Yet, under cover of the doctor's protection, such women frequently conduct the entire labour in his absence. They are exempt from the rules and the inspection and supervision which are applied to the certified midwife.

The Medical Officer of Health for West Ham, Dr. Garland Collins, in his Report for 1928, complained:

"There are still too many medical practitioners who are content to allow an unqualified woman to attend their patients during childbirth. It is, of course, assumed that the pregnant woman who engages a medical practitioner to attend her will send for him at the onset of labour. But actually this seldom happens in the type of case I have in mind. The unqualified woman—the handy-woman—is sent for first. On arrival she examines the woman and only sends for the general practitioner at the last moment if something is obviously abnormal, frequently she sends only after the child has been born. . . ."

"It has been brought to my notice that Mrs. G., an unqualified woman, has conducted confinements in this Borough. On inquiry being made, Mrs. G. stated that she works with several doctors, and undertakes the actual delivery if asked to do so by the doctors engaged."

Dr. Collins gives two cases of still-birth in which he was able to ascertain that the doctor had not been sent for till after the birth. When the handy-woman delivers it is usually, of course, the doctor who notifies the birth.

Dr. Collins suggests that it should be made illegal for any unqualified woman to accept payment for attending a woman during labour, whether working with a medical practitioner or not. On the other hand, the Departmental Committee on the Training and Employment of Midwives, which reported in 1929, though it deplored the attendance by unqualified women, declared that legislative attempts to suppress it had largely failed and nothing could be gained by further legislation. A more grievous assertion of social impotence could scarcely be made. To the lay mind it would seem not impossible to place upon the doctor the legal obligation to be present at the confinements for which he engages himself, and the responsibility for insisting that his patient shall be under the care of a qualified nurse. It is for the community to insure that trained assistance shall always be available. The Departmental Committee was doubtless led to its attitude of soporous *laissez-faire* by consideration for the susceptibilities of the British Medical Association, which presented a memorandum supporting the employment of handy-women, though it deprecated the term, and declaring it impossible for a certified midwife to be in attendance at every confinement. The B.M.A. further claimed that a registered midwife acting under a doctor should not be subjected to inspection.

In Holland the training of the certified midwife extends over three years, in Sweden two. In Italy, where the maternal mortality is only 2.54 per 1,000 births, as compared with 4.0 per 1,000 births in England and Wales, the midwife has two years training in a State

School of Midwifery. In New Zealand the training extends over a year and four months.

In this country, whilst the old untrained *bona fide* registered midwife has not entirely died out, there are also the three-months-trained midwives, who were registered between 1902 and 1916; the six-months-trained women registered between 1916 and 1926, and the hospital-trained nurses, who took a four-months midwifery course during that period; and the twelve-months-trained midwives, and the hospital nurses with six months' midwifery training, who qualified after the Midwives Act of 1926.

As to the quality of the training required for British midwives by the Central Midwives Board, Jellett says: "I cannot express even a qualified approval."<sup>1</sup> He considers it unwise to allow women to practise as midwives who have not also received a general nurse's training in hospital, and complains that for the midwife there is no uniform standard of training. Though to obtain her certificate she must attend, examine and deliver the patient in twenty labours, it is only necessary that five of these should be nursed in hospital. The rest of the training may be taken under any recognised midwife and medical practitioner. The standard of asepsis which the midwife is taught is left to the individual teacher, who may, or may not, have grasped the principles and practice of asepsis.

"Numbers of nurses," says Jellett, "have never received training in asepsis; others have forgotten what they once learnt."

Aleck W. Bourne, obstetric surgeon at St. Mary's and Queen Charlotte's Hospitals, and a teacher and examiner of midwives, has complained: "Watching the work of some nurses convinces me that the true principles of asepsis have never been learnt." He had often

<sup>1</sup> *Cause and Prevention of Maternal Mortality*, A. J. Churchill, London, 1929.

seen a hand, "not too clean, dipped in lysol solution and thereby regarded as aseptic," though the lotions<sup>1</sup> used at the bedside are powerless to kill microbes, except after such prolonged immersion as is impossible in ordinary clinical work. He had seen a nurse don sterilised rubber gloves, and then proceed to handle blankets and other objects, regardless of the fact that the gloves were thereby contaminated. The use of rubber gloves is actually discouraged in some hospitals, because "nurses think they can do as they like" when wearing them; the Report of the Scottish Board of Health even speaks of the same swab being used to wash patient after patient in lying-in wards—an outrageous proceeding, even were there not the peculiarly acute danger of infection which exists during the puerperium.

So far from being obscure to the minds of trained midwives and nurses, the principles of asepsis should be taught in the elementary schools and made common to everyone. Knowledge of how to sterilise utensils and fabrics, and to keep them sterile, and the surgical meaning of cleanliness of the bed and the sick-room are needed in the minor ailments and accidents of the home and the workshop; it is imperative that the mother herself, and every member of her household liable to enter the lying-in room, or to handle the new-born infant and prepare its food, should be made aware of these things.

When entering upon her training the midwife must have reached twenty-one years of age, but no entrance examination is set for her, and she is expected to meet no educational standard of fitness to take her course. It is left to the individual teacher or institution to decide

<sup>1</sup> The Departmental Committee on Maternal Mortality quoted researches showing that lysol as used in midwifery to sterilise hands and instruments fails to kill puerperal fever producing bacteria, and that the brands of lysol on the market differ in quality. The committee recommended rubber gloves sterilised by more reliable antiseptics.

whether she is capable of receiving the necessary instruction. Many candidates have received only an elementary school education and have been employed in factories, or shops, or domestic work since their school-days ended at fourteen years.<sup>1</sup> The Departmental Committee on the Training and Employment of Midwives recommended a simple entrance examination in reading, writing and arithmetic, rejecting the standard of the Oxford and Cambridge Junior Local Examinations as too high. Yet the same Committee advocated increased scope and responsibility for midwives, and urged that the conduct of normal labour and the decision whether to send for medical aid should be left in their hands.

At the best, the six or twelve months' course of the registered midwife can in no case be compared with the scientific education which the medical practitioner could and should acquire in six years of university and hospital training. In any case the midwife is not permitted by the Rules of the Central Midwives Board to do what may be necessary in case of emergency, nor has she the training or education to take the steps a doctor might find necessary. She is not permitted to summon a specialist, nor to send a patient to hospital. These courses can only be adopted by the doctor, and the British Medical Association insists that the midwife shall not be given such power.

The Rules of the Central Midwives Board direct that:

“In all cases of illness of the patient or child, or any abnormality occurring during pregnancy, labour or lying-in, a midwife must forthwith call in to her assistance a registered medical practitioner.”

<sup>1</sup> In France young girls are employed in subordinate work in the Mother and Infant Welfare Centres, with a view to training them as midwives later.

“Midwives must not, except under a grave emergency, undertake operative procedure, which is outside their province. The question whether in any particular case such procedure or treatment was justified will be judged on the facts and circumstances of the case.”

When summoned in one of the grave and urgent emergencies which may arise in childbirth, the nearest medical practitioner is not under a legal obligation to attend; and though he may be willing to give his services, it may not be possible to get in touch with him immediately. Grave injury, and even the death of mother and child, may occur before he can arrive to give essential aid. Appearing when their condition has grown desperate, he may be compelled to resort to extreme measures, which might have been avoided had he been in charge of the case at an earlier stage, such as destruction of the child by craniotomy, in order to save the life of the mother, a terrible expedient, intensely harrowing to the mother. The loss of her child in a manner so awful, is an ever-recurrent grief, often producing a serious and lasting psychological depression.

Many a woman has died undelivered or succumbed to hæmorrhage through delay in procuring medical aid.

Whether attended by a registered or unregistered midwife or a doctor, and whether a doctor happen to be present or not when the child is born, the average working-class mother lacks adequate nursing care during the lying-in period. Indeed the quality of the nursing is often lowest in doctor's cases, for the patient, unable to pay the midwife's fee as well as that of the doctor, resorts to an untrained handy-woman, or a neighbour or relative giving part-time attendance.

The midwife, in some cases, calls night and morning for the first two or three days, and thereafter once daily, to wash the baby and adjust the dressings of the mother.



## LONG NEGLECT OF MATERNITY 63

Many midwives limit their attendances to one visit daily from the first. During the absence of the midwife the welfare of her patients is left to whatever untrained aid can be procured.

In a well-managed maternity institution or a comfortable upper or middle-class home the mother is forbidden to touch any pads or dressings, and is not allowed either to defecate or urinate without the assistance of the nurse, under strict aseptic precautions. Yet, for the working-class mother one visit a day from the midwife is held to be sufficient. All the requirements regarded as essential for richer patients go by the board where the poor are concerned.

Says Jellett:

“For a varying time after labour is over the lochial discharge may be heavy, and in some cases will soak through the outer dressings. When this occurs pads must be changed and a new one put on, and this may have to be done every two to four hours.”

Who is to perform such services for the mother during the midwife's absence? The home helps supplied by some local authorities are strictly forbidden to do any nursing, but nurse they must when the midwife is away, or leave the mother to attend to her own needs.

## CHAPTER FIVE

### THE MIDWIFE'S CASE

THE midwife is often a heroic figure, toiling on her bicycle from case to case to do her office; hastening at any hour between dawn and dawn, perhaps over rough country roads and steep hills, through torrential rains and almost impassable snows, in response to the urgent call. Sometimes she arrives in a state of exhaustion, unfitting her for the arduous duties awaiting her, as the report of the Departmental Committee on the Training and Employment of Midwives observed.

Night after night she may have to forego her rest. Her daily attendance on lying-in mothers and pre-natal visits make it difficult for her to snatch a sleep during the day. Often she has neither time nor opportunity to get an adequate meal. She must deal with an unending succession of painful crises, summoning her energies to the aid and encouragement of women labouring under intolerable pain.

During the final stages of labour, and when the child is born, there is too much for her to do, apart from the unshared responsibility. A doctor has a nurse to wait upon him. The midwife must rely on herself for every requirement.

Every case brings its moments of tense anxiety; for in spite of the glib phrase, "normal labour," as Sir Alexander Simpson justly says:

"No case of labour can be defined at the outset. . . . Until the labour is completed, and completed within a reasonably safe period, it cannot be classed as natural . . . apart from all accidents and

interferences, the mortality both to mother and child becomes greater the longer the duration of labour.”<sup>1</sup>

If delivery be delayed for any reason, if complications arise, if suspense has become acute, and the doctor having been sent for fails to arrive with promptitude; then the midwife's anxiety becomes almost maddening. The lives of a mother and infant hang in the balance. If a sensitive and nervous woman, she is tortured by self-questioning as to whether she ought to have taken alarm and sent for assistance at an earlier stage; perhaps tormented by apprehension that she may be censured by the Local Supervising Authority and the Central Midwives Board. The more that public attention is turned on the question of maternal mortality, the more she may be unnerved by the possibility of a death amongst her patients; yet greater than this is anxiety for the patient. How much easier would be her lot if relieved of such anxiety by the presence of a medical practitioner competent to act in all emergencies.

A midwife of long standing told me a common story. Stationed in a country district, she was called to a mother whom she had nursed already in more than one normal confinement. The child was born during the night. The placenta could not be expelled, and after two hours of anxious effort, the midwife roused the husband of the patient and asked him to take a note to the doctor. The man had to walk a couple of miles to the village where he could borrow a bicycle, and then had to pedal the machine some six miles to the doctor's house. The midwife had said nothing to alarm him. His wife had come through previous confinements without difficulty. Phlegmatic of temperament, he thrust the note into the letter-box, pulled the night bell, and

<sup>1</sup> Sir Alexander Russell Simpson, M.D., LL.D., D.Sc., F.R.S., Emeritus Professor of Midwifery Edinburgh University: *Encyclopædia Britannica*, thirteenth edition.

immediately set off home. The midwife, waiting in terror beside the mother now suffering from dangerous hæmorrhage, met him with horrified reproaches when she learnt that he had not waited to ascertain whether the night bell had been heard. Only when the last hope seemed gone, she heard with intense relief the sound of the doctor's gig.

Stationed sometimes in a remote village, sometimes in a poor quarter of a squalid industrial town, the midwife is often wholly debarred from social intercourse and amenities by her exacting duties and, if she have no other source of income, by the meagre earnings of her profession.

The fees paid to midwives in the East End of London vary on the average from £1 to 30s. for a first child, from 12s. to 21s. for subsequent children. In West London fees are sometimes as high as 50s. for a first child. In the Lancashire textile area, where a large proportion of married women are working in the mills, and a maternity benefit for both husband and wife is drawn, fees run up to 42s. for a first confinement, and 35s. for subsequent births. In the Midlands the average fee is said to be 25s.

Where the family is in distressed circumstances, the father out of employment and out of insurance benefit, as so often happens, a kind-hearted midwife is often induced to reduce or forego her fee, and even to pay for urgent requirements from her own purse.

A midwife tells me that more than once, in households of poverty and misfortune, she has taken off her underskirt to wrap round a new-born baby for whom no garments, or even wrappings, were forthcoming. Another says it is a common thing for the lying-in mother to borrow a nightdress from a neighbour, or even to make use of one of her husband's shirts, for at ordinary times she sleeps in part of her day clothing. Another midwife of long practice tells me that before the war it was her experience that all but the poorest

mothers had a maternity cupboard, in which, for many weeks before the confinement, they would be collecting invalid foods for themselves during the confinement, and little extras also for the nurse—cocoa, biscuits, bovril and so on, wool and clean linen. Now, she says, it is rare to find such preparations; it seems that the daily struggle to make ends meet has increased. In the homes she visits, bowls, basins and towels are often lacking, saucepans are battered and worn, the whole equipment of the home deficient, and almost in the last stages of over-use. Often the midwife, finding the mother without household assistance, has to call on the neighbours to give such aid as they can. Help is seldom, if ever, denied, but it is given as and when the neighbour can snatch time from the clamant work of her own family.

Payment of maternity benefit is delayed until after the midwife's attendances have ceased. Thus the mother lacks the cash which might have aided her to make some provision for the confinement, and the midwife, having left, may lose her fee through the money being spent on other pressing needs. The rent may be in arrears and the landlord threatening eviction, a child may have fallen ill. There is no surplus to spare for emergencies in poor homes.

It is incumbent on the midwife to keep herself well supplied with frequently washed print dresses and aprons, and in general to pay particular attention to the cleanliness of her dress and person. She should live in a decent, well-kept home, and maintain herself in good health, both on account of her arduous duties and because she must be sane and clean in person to be in contact with mothers during their confinement. The rules of the Central Midwives Board direct:

“The midwife must be scrupulously clean in every way, including her person, clothing, appliances and house.”

In all these respects she is liable to inspection. She must supply herself with the tools of her trade, appliances for vaginal and rectal injections, a catheter, a clinical thermometer, efficient antiseptics for cleansing the hands, for douching, for cleansing the eyelids of new-born infants. Wool and tow for making pads, and such drugs as may be required, though not mentioned in the Rules, must be carried by the midwife to insure the proper performance of her duties, especially in poor homes.

Two midwives practising together in an East End district inform me that their annual bill for drugs, wool and appliances is £40, and that in order to live and pay their way they must each take 150 cases annually. That allows less than two and a half days to each case, without a day to spare for holidays. Assuming that a day is given to the labour, that a couple of short visits are made the day following, one of an hour, the other somewhat less, and that something less than an hour, in addition to the journey to and from the patient's home, is devoted to nursing on the remaining nine days, the equivalent of two and a half days is practically absorbed. At this rate the midwife must dovetail her cases very closely to fit them all in. Even so, there is little or no time for ante-natal work, and the patient will often get less attention than the conscientious midwife would desire to give; for, however carefully she may space her bookings, exact dates cannot be given and two or three patients may easily be confined within a few hours of each other. A couple of midwives living and working together have a better chance of coping with professional emergencies than a solitary worker; but they too will often find themselves under great pressure of over-work if so many cases are attempted.

These two have worked on without a break for five years. They hope that one of them may get a holiday this summer. They would like to take a post-certificate

course every two years, to keep abreast with obstetric ideas, but can afford neither the time, nor the fees, which are £8 8s. for four weeks and £16 16s. for eight weeks' post-certificate tuition.

It has been urged, and rightly, that the midwife's fee should be raised; but even the better-to-do working-class families cannot afford to pay a higher fee; the cost of the confinement is already too high for them. The midwife's position must be improved, but the Nation must find the means.

When the midwife has too many patients on her hands she must inevitably leave some of her duties to someone else, who will usually be an untrained char-woman, or a member of the patient's family, perhaps a little girl who has recently left school. How inadequate is the attention some midwives find time to give to their patients may be judged from the fact that the Departmental Committee on the Employment of Midwives was impelled by the evidence laid before it to suggest that the Rules of the Central Midwives Board should be amplified so as to indicate that the midwife should not delegate to anyone save a trained assistant attention to the baby's cord, inspection of its eyes and mouth, the taking of the mother's temperature and pulse, attention to the genitals, and such treatment as the passing of a catheter. That such a reminder should prove necessary is a sad reflection on midwifery practice, which suffers indeed over-much from delegation of duties and responsibilities, from the more qualified medical practitioner to the less qualified midwife, and thence to the wholly unqualified aid.

The Incorporated Midwives' Institute laid evidence before the Departmental Committee on the Training and Employment of Midwives, showing that the earnings of the independent midwife vary from £30 to £275 a year, and that many midwives, prepared to give their whole time and without other income, make only from £90 to

£120 per annum, that bad debts ranging from 3 to 33 per cent. are often incurred, and attempts to recover them through the County Court are costly and ineffective. One midwife stated in evidence that she made £350 a year, but obviously she could not personally attend to the "cleanliness, comfort and proper dieting of the mother and child," as directed by the rules of the Central Midwives Board.

Whilst many midwives are overworked, others do not get the patients they need to make even a bare livelihood; at times they have an excessive number of cases, at times too few to provide a subsistence. Some women are acting as midwife one week and finishing trousers for a factory the next. Their poverty and the diversity of their employment is hardly calculated to preserve the nursing standard. The registered midwife is sometimes severely handicapped by the competition of nursing institutions, training schools and hospitals, and of the unregistered handy-woman, who works for a lower rate under the cover provided by complacent medical practitioners.

If a midwife has come in contact with a case of infectious disease she must notify the Local Authority and is suspended from work. She is compensated for the bookings she cannot fulfil; but not for the loss she incurs through intending patients failing to book for fear of contracting disease. If her patient, after a day and night or more in labour, is removed to hospital, the midwife loses her fee.

When engaged for a confinement the midwife is directed by her Rules to inquire as to the patient's previous pregnancies and labour, and if there has been an abortion or premature or still-birth, she is directed to urge the patient to seek advice from a doctor or hospital.

Dr. Veitch Clark, the Medical Officer of Health for Manchester, has rightly urged that the fees in such cases should be guaranteed to the midwife by the com-



munity. As a public official he is courageous enough to advocate a subsidised service of midwives with a guaranteed income.

"For the midwife it ought to be a matter of one patient at a time," says Jellett. Under present conditions this is impossible, but with a salaried staff of municipal midwives one patient at a time would be the rule, with proper provision for rest and holidays for the midwife herself.

Though her present training is briefer, and less thorough than it should be, it is longer and more costly than that for other employments giving so small a return and entailing such arduous duties. The earnings of a midwife are much lower, as a rule, than those of a trained nurse employed in other cases.

A National Midwifery Service should subject its candidates to an entrance examination and train gratuitously the accepted candidates, paying them a wage whilst in training, as though they were apprentices to a trade, or junior employees in the Post Office or other branch of the Civil Service. The period of training should be increased to four years, and should include an efficient education in general nursing. The final examination should include clinical tests. Attendance at an annual post-graduate course should be included in the time-table of the municipal midwife, her salary continuing meanwhile, as it would during her holidays. She should be eligible for pension like most other public officials.

In part these ideals are beginning already to be realised. Some Local Authorities in this country employ whole-time salaried midwives, or guarantee minimum salaries, or make subsidies to midwives. The salaries range from £50 per annum plus a fixed fee per confinement, to £150 or £250 per annum with fees returnable to the Local Authority. The subsidies range from £10 to £80 and the guaranteed salary from £120

to £230. Such steps are taken by some Local Authorities where there is a shortage of midwives for necessitous or general cases.

The Queen's Institute of District Nursing employs fully trained nurses, who, in return for six months' training in district nursing, agree to serve for one year, or two years if they receive a further training also in midwifery. They are supplied with bag and equipment, bicycle, motor-cycle, or car in some cases. They have a salary of from £68 to £80 a year or more, with £1 1s. for board, £8 for uniform, and the cost of at least two furnished rooms, fire, light and attendance. County Nursing Associations employ village nurse midwives, whom they train without charge, on condition of two or three years' service thereafter, during which they make an allowance for uniform, board and lodging, and pay a wage of £30 or £40 a year. Some nursing associations make pensions of £45 to £50 a year to their nurses at fifty-five years. There is a "Long Service Fund" of £30 a year for Queen's Nurses who retire after twenty-one years' service.

Queen's nurses and village nurse midwives are supposed to get a month's holiday a year and half a day a week and an occasional week-end off duty. In many districts the emergency staff retained by the nursing association is too small to supply the required substitutes, and whether she be ill or her holiday overdue, the midwife has often to remain at work when it is imperative that she should be relieved. Yet, even so, her lot is less hard than that of the independent midwife, for whom no relief will appear at any time. The Queen's nurses and village nurse midwives are insured under the National Health Insurance Acts. Moreover, the nursing associations pay full salary for a time in case of illness. The independent midwife may not even be a voluntary contributor to the National Insurance.

The excellent midwifery record of the Queen's

nurses, who have attended over half a million patients with a mortality of about 1.8 per 1,000 cases, is doubtless in part due to their superior training, for be it remembered they are all fully trained hospital nurses before taking their course in midwifery; in part to their superior conditions of employment and the consequent higher degree of comfort and security they enjoy; in part to their having better facilities than the independent midwife for obtaining prompt and efficient medical aid.

The Rules of the Central Midwives Board and the discipline exercised over midwives by the Board and by the Local Supervising Authorities have lately been subjected to much criticism. The Departmental Committee on the Training and Employment of Midwives, being impressed by the critics, declared:

“The time has arrived when a system of discipline, setting out in precise language what a midwife may and may not do, should be reconsidered and, we suggest, superseded. Such a code was, no doubt, necessary in the past, but we cannot regard the mode of its application as altogether consistent with the improved status and responsibility of the midwife which we believe it is in the national interest to promote.”

The general tendency of the Committee's recommendations is to leave the conduct of her case rather to the midwife's discretion than to regulate her procedure by Rules. The present system of censuring, suspending or removing from the roll any midwife who breaks the Rules of the Board was condemned by the Departmental Committee. It proposed that the Rules should no longer possess definite statutory authority and penal significance, but should be treated as advisory guides and “examples of the standard of practice to which the midwife should attain.” To relax the discipline thus,

without increasing the standard of training, and without establishing refresher courses to keep the midwife up to hospital standard, would be a step dangerous in the extreme. A wiser and more genuine mode of raising the midwife's status is to provide her with a sufficient assured income and improved working conditions.

Rule E of the Central Midwives Board, which regulates the duties of midwives, was characterised by the Departmental Committee as: "in parts deficient, in parts diffuse, in parts meticulously detailed."

This sharp denunciation is hardly born out by the not very drastic alterations suggested by the Committee. Yet there can be no doubt that the directions given in Rule E, to guide the midwife as to when she should summon medical aid, contain grave errors, both of omission and commission. The express sanction to the midwife not to summon a doctor if the presentation is an "uncomplicated breech" rouses the Departmental Committee to make a very moderate suggestion. It urges that as "a disquieting feature of present-day midwifery is the high foetal mortality which occurs in breech cases," it would be "of service" to reintroduce the former rule, that a doctor must be summoned to a breech presentation in the case of a first child. This rule, it may be observed, still exists in Ireland. Surely the learned John S. Fairbairn and Dame Janet Campbell might have had the courage to go the whole hog in this very critical matter by calling for medical aid in all breech presentations. In New Zealand only the uncomplicated vertex may be delivered by the midwife without aid. Professor Beckwith Whitehouse,<sup>1</sup> addressing the Midwives' Association of Worcester in 1927, observed that in breech deliveries twenty-six out of every hundred infants die, and that a breech delivery is "a big responsibility" for the midwife to shoulder unaided. He explained that:

<sup>1</sup> Reported in *Nursing Notes*, September 1, 1920.

“The usual practice of doctors to-day, in the case of primiparæ, is to convert any breech presentation into a vertex; the reason for this, of course, being that otherwise it is impossible to know whether the head will come through the brim.”

He added that whilst in some cases it may be easy thus to alter the position of the child, it may be impossible if the legs are extended, a condition which frequently occurs, as shown by radiographs taken in the last four weeks of pregnancy. Therefore a breech presentation should always be regarded as a potential danger sign. During the past twelve months he had himself twice failed to convert a breech into a vertex, even under full anæsthesia with the advantage of an operating table. The midwife is helpless in meeting such emergencies. One of the cases of puerperal fever he had had to treat the previous year occurred in such a case. The midwife had failed to recognise that she was dealing with a breech with extended legs, and did not send for medical aid till the poor little breech was firmly impacted in the pelvis. The doctor had a difficult task to effect delivery.

Dr. Eardley Holland, in his *Causation of Fœtal Death*, has devoted much space to the difficulties of breech delivery, on account of the high and, as he believes, preventable mortality in such cases.

As the Departmental Committee pointed out, Rule E makes no mention of inefficient uterine action, one of the most common forms of emergency in which medical aid is required, nor of disproportion between the child's head and the mother's pelvis, a most serious and unfortunately common condition, which should be detected during pregnancy and provided for by appropriate obstetric treatment. Since it requires treatment which the midwife cannot give, it is astonishing that the Cen-

tral Midwives Board has failed to draw special attention to it. In the vast majority of cases the contraction is slight and only to be detected during the last few weeks of pregnancy. Women with slight pelvic contraction may pass through several labours successfully, but sooner or later the child may be larger than usual, and disaster may overtake them.

"Pelvic measurements, no matter how carefully you take them, will sometimes let you down," says Beckwith Whitehouse. Eardley Holland declares that to detect slight contraction requires "a degree of skill only to be acquired by careful training and long experience," while Jellett insists that external measurements are not sufficient and that internal pelvimetry must be resorted to in doubtful cases. It would be absurd to expect all this from the midwife, for even the physician, with a scientific training and the facilities of hospital equipment, is often led astray.

Rule E directs that a doctor must be summoned if the placenta be not delivered two hours after the birth of the child. In this exceedingly common difficulty New Zealand midwives are only permitted to wait one hour before summoning aid.

In Ireland the midwife is not permitted to administer to a woman in labour any drug other than a simple aperient before the birth of the child. If she considers that any drug is required she must send for a medical practitioner. In New Zealand no midwife may administer ergot, pituitrin or other ecbolic drug, before or during labour, or administer chloroform or any other anæsthetic except by the direction of the medical practitioner.

In this country midwives make extensive use of pituitrin. A midwife writes to me:

"Modern midwives do not douche without medical advice, except perhaps in very severe

cases of post-partum hæmorrhage, but generally give pituitrin instead."

Thus she has been trained. Dr. Eardley Holland has pointed out that the action of this powerful ecboic as a possible factor in producing excessive cranial stress, which may be fatal to the infant, must not be overlooked. The Report of Maternal Mortality in Canada published by the Canadian Department of Health utters grave warnings in respect of this drug, pointing out that it was administered to 21 per cent. of the women whose deaths were investigated. Ten letters of advice are mentioned declaring it to be dangerous, one doctor stating that he knew of many unfortunate women killed by this "violent drug." Rupture of the uterus as well as injury to the infant's head may result from its injudicious use.

The Departmental Committee on the Training and Employment of Midwives discussed the vexed question whether midwives should be permitted to use drugs, and observed:

"Midwives cannot be regarded as persons fitted either by training or experience to be given complete freedom in the use of drugs! . . . and ought not to have laid upon them the responsibility for the administration of hypodermic injections, e.g. morphia or pituitrin; yet no absolute ban can be placed on their use of such drugs because of the emergencies with which they may be faced."

All such controversies and compromises *faute de mieux* would be avoided if a qualified medical practitioner were present at every birth.

Medical practitioners in cases of grave emergency are often obliged to take grave risks. Sometimes they make mistakes. Their profession upholds them; and we who submit ourselves to doctors must make the best of them, for the human mind, even with a pro-

longed scientific training, is not error proof; yet in the absence of such training the percentage of error will inevitably be higher.

Anæsthetics, analgesics and sedatives are more generally used to ease the pains of the well-to-do mother than of her poorer sister. This point was urged upon the Departmental Committee on the Training of Midwives, which replied by protesting that these preparations are not without danger to mother and child. The question was further considered by the Departmental Committee on Maternal Mortality, which expressed the view that an anæsthetic should be given in every obstetric operation including the application of the forceps and suture of the perineum. For operative work a second doctor should be present to ensure the safety of the patient and to avoid risks of sepsis through the doctor attempting to fulfil two functions at once. Where intolerance of pain is very pronounced an anæsthetic or analgesic may hasten rather than retard delivery and spare the patient from dangerous shock.

Whilst anæsthetics are largely employed for the prosperous, even in normal labour, and in many hospitals are administered to the majority of normal patients, the poor mother delivered in a working-class dwelling frequently suffers severe operative treatment without such relief. The British College of Obstetricians and Gynæcologists, the British Medical Association, the Royal College of Physicians and the Departmental Committee itself concurred in the view that the midwife is not qualified to administer anæsthetics. It is therefore clear that the woman attended only by a midwife must display a greater degree of fortitude than is expected from more fortunate women.



## CHAPTER SIX

### THE HOME HELP

By 1927 only fifty-seven Local Authorities had taken advantage of the power granted by the Maternity and Child Welfare Act of 1918 to supply "home helps" to necessitous mothers during the confinement. The arrangements for this service made by various authorities differ considerably. The suggestion of the Ministry of Health that the "helps" should receive three months' training in cookery, mending and food values has in most cases been disregarded. In Sweden a very much ampler training is thought necessary for the women undertaking such work. Dr. Helen McMurchy of the Canadian Health Department has urged that the labours of the home help should be raised to the dignity of a profession, but the Local Authorities in this country have hitherto mainly regarded her as a char-woman.

Birmingham arrangements are amongst the best. Home helps are supplied there for the confinement or if the mother is absent or incapacitated on account of any non-infectious illness. Forty home helps are employed to cover various districts, the Health Department paying them 5s. a day when in work, but no retaining fee. They provide their own food. Their hours are from 8 a.m. to 6 p.m. They attend as a rule for ten or twelve days, excepting Sundays unless the patient's husband is at work on that day. Mothers are requested to apply for them a month before the confinement, but late applicants are not refused, and if application is made before 9.30 a.m. the arrangements

for the help can be made the same day. This elasticity contrasts very favourably with the red tape obtaining in other districts. The charge made by the Health Department to the patient for the services of the home help is 1s. per day where the income of the family is below 9s. per head per week excluding rent; 2s. if the income is between 9s. and 12s., and so on, graduated up to 5s. per day when the income is over 18s. per head per week. Where the family income is less than 5s. per head the voluntary committee of the Child Welfare Centre or some charitable organisation sometimes pays the minimum fee.

In Glasgow the home helps are paid 5s. a day, and are usually supplied for eight days, excluding Sundays, unless Sunday occurs within four days of the birth. They may be obtained for any case of maternal illness if there is a child under five years of age. Patients pay a minimum of 1s. a day on a scale graduated to income. Applications must be made one month in advance, and the whole of the fees must be paid at the time of application.

In Birmingham, where there are 17,000 births per annum, home helps were supplied in 404 cases. In the same year in Glasgow only 132 were supplied, in respect of whom 59 patients paid 1s. a day, 29 paid 1s. 6d., 3 paid 3s. 6d.; none paid more.

In Huddersfield the Health Department supplies both home helps, who act as housekeepers, and home assistants, whose duties are rather those of charwomen. The former are paid 45s. per week, the latter 11d. per hour. Dr. Moore the Medical Officer of Health writes:

“Their work is good up to a point and the idea is popular—yet their standard of cleanliness approximates too closely to those of slumdom to be satisfactory to me.

“It was my intention when this work was started

that the home should be cleaned out thoroughly, drawers removed, cupboards emptied and so forth, until the bare frame of the house was exposed, the whole scrubbed and thoroughly cleansed, the needful amount of washing of textiles accomplished and every vestige of dirt eliminated. I did not exactly aim at the surgical cleanliness of an operating theatre, but I wanted to come as close to it as I could. . . . In this case I have resigned myself to be satisfied with a medium."

In West Ham home helps are supplied without charge, and only to families where the income does not exceed 8s. a week per head including rent. Application must be made at seven months' pregnancy. This is a common rule. Though many poor mothers still do not know of the service, it is already largely used. Out of the 5,913 births in the area in 1928 there were 954 applications for home helps, of which 825 were granted. Here, as elsewhere, the time limit and the income limit occasion hardship.

One mother complains that she was denied a home help because the Health Visitor miscalculated the family income; another that she lost her chance because she herself had miscalculated the date of the birth; another because she had a premature birth. A midwife complains that her patient was refused a help because her husband, long unemployed, got three months' work which was ending at the time for application. The income was thus temporarily over the scale. The husband suffered from chronic phlebitis. The wife had a miscarriage with puerperal sepsis twelve months before. She had another child two years old.

Such grievances are inevitable under an income scale. A free home help service is the correct solution. Since there is no lack of home helps it ought not to take an efficient administration three months to arrange the

engagement. West Ham and other districts fixing a hard-and-fast time limit should take a leaf out of the Birmingham book.

The case of the West Ham home help is not less grievous than that of the poor mother she serves. She is paid by the Council the bare pittance of 25s. for a fortnight's service and is not permitted to take any food in the patient's house. Almost invariably she returns to do the third week's washing, though unpaid for this service, because she recognises that the mother is not fit to stand at the wash-tub and the mangle so soon after the birth of the child. Her spirit is certainly more generous than that of the Borough Council, which pays her so shabbily. Her instructions are to work under the supervision of the Health Visitor, and "to be at hand" during the labour. She is frequently up with the mother the whole night of the labour and sometimes also the subsequent night. She is directed to care for the mother "generally, especially as regards cleanliness and food"; and "to see that the infant is properly fed and cared for; and, if possible, put to sleep in a separate cot." She is to wash and dry the labour clothes and do the ordinary family washing, prepare the meals, tidy the house, attend to the children, and see that those going to school attend punctually and are clean and tidy.

In one district where home helps are supplied by the Council a delicate young woman with a young child of her own and emaciated by privations, for her husband had long been unemployed, worked as home help to a mother who had eleven children under the age for leaving school. Another woman served as help to two households at one time, one mother having given birth to a premature infant. She complained that she had only been paid the usual 25s. for a fortnight's work, although her duties had been doubled. Such decisions are keenly felt where the scale of pay is so grievously low. A third home help had assisted where there were

eight children under seven years, including two sets of twins. She had several children of her own also to care for.

Certainly the duties are strenuous. The homes are crowded, many necessaries are lacking, the children perhaps unruly. The mother was probably unfit for her work some time before she took to her bed, and arrears of washing and cleaning have mounted. The home help must get the place clean and keep it to the satisfaction of the Health Visitor. Should she possess a pair of decent sheets not in use, she will often put them on the patient's bed, and bring round needed utensils to save time and preserve appearances in face of inspection. Yet she, too, is of the submerged tenth, and usually a recipient of outdoor relief, which will be docked to the extent of her earnings unless some kindly ministrant should by chance mitigate the rule. Why then is she willing to undertake these arduous duties? In order to handle money instead of food tickets and thus pay a few shillings to the landlord or to buy some clothing, though to do so entails hunger.

The poor home helps of West Ham lately roused themselves on learning of the higher rates paid elsewhere, and wrote to the Borough Council asking an audience. They were received in deputation, and a committee has been appointed to consider their application for increased pay.

Obviously the wage of the home helps in Huddersfield is far too high for the average working-class family to pay; yet it is not too high; for the arduous duties involved; and the need for the home help to keep herself at a proper level of comfort and cleanliness for attendance upon a lying-in woman and a new-born infant make sweated payments to her an evil even more grievous than in the average case. It is invariably stipulated that she shall do no nursing, but given the midwife's attendance, which at most is an hour to an hour and

twenty minutes a day, and frequently very much less, the help must obviously perform a great many services for the patients. In practice she commonly washes the baby, and if she have anything unhealthy about her she may easily be a source of pemphigus neonatorum, which has frequently been traced to some apparently trivial scratch on the hands of the nurse. Dr. Janet Campbell reports the case of an independent midwife, who had a small "crack" in her finger, and in whose practice fourteen cases of pemphigus occurred in rapid succession. One child died, four were removed to hospital, where three of the nurses contracted the disease. A case of puerperal fever has been ascribed to infection from a home help suffering, as so many poor women do, from varicose ulcers.

In every district there should be an agitation to insure that the Local Authority shall provide home helps for lying-in mothers and that the home help shall be paid an adequate standing wage. When this is won, as it can and will be by agitation, the rates for such service will tend to mount in accord with the wage paid by the Local Authority.

This will heighten the need for the provision of a free home help service for all confinements.

The Departmental Committee on Maternal Mortality quoted important observations by Dr. R. M. Fry on the effect of fatigue on the capacity of the human blood to destroy disease-producing bacteria. A woman the power of whose blood to kill bacteria had been tested for several weeks undertook a task which reduced her to a state of exhaustion. A sample of her blood then taken revealed a sharp fall in bactericidal power.

CHAPTER SEVEN  
ANTE-NATAL CARE

IN medical and Governmental circles there is to-day a very wide recognition, in theory, if not invariably in practice, that childbirth should not be provided for as an isolated incident, but that the entire period covering pregnancy, the puerperium and lactation should be safeguarded.

The need for ante-natal medical supervision and examination is at present strongly emphasised; yet comparatively few expectant mothers, whether rich or poor, have accepted, in practice, the view that they should subject themselves to a complete physical examination, that their pelvic measurements should be taken, the size of the uterus noted, the position of the child and the relationship of its head to the pelvic brim ascertained, their urine frequently tested and other symptoms observed, in order that any possible abnormality may be foreseen and prepared for.

Expectant mothers are still unfortunately inclined to believe, and to hear from their mothers and aunts, that pregnancy must inevitably be a time of suffering, that sickness, headache, swollen legs and other painful ills are natural to women in that condition, and must be endured with as little complaint as possible till the baby is born. Actually such symptoms, though grievously common, are neither normal nor inevitable. Moreover, it is a serious mistake to treat them lightly. Every effort should be made to overcome them, for they may be the precursors of serious or fatal illness at a later stage.

Dr. Comyns Berkeley at the National Conference on

Maternity and Child Welfare at the Guildhall in 1927 threw out the suggestion that lectures on ante-natal care should be broadcasted by wireless. An excellent idea.

To achieve its purpose ante-natal care of the mother must build up her general health, insure that her food is sufficient in kind and quality, that she rests enough, sleeps enough and has enough, but not too much, exercise and plenty of fresh air. Poor health and the neglect of apparently minor ailments may prove as fatal in the confinement as a contracted pelvis.

Attention to the teeth is of great importance. Dental sepsis is usually present in women suffering from the toxæmias of pregnancy. Seventy per cent. of the patients treated in the ante-natal clinic of the Royal Free Hospital are found to require dental treatment, and no case of abortion has been traced to such treatment. Every mother should get her teeth examined early in pregnancy; better still, whilst as yet only a potential mother, she should have them regularly attended to.

Mothers should endeavour to shoulder the supreme duty of keeping in good health and tranquil mind for their children's sake. They cannot all be physicians, but they should learn the outstanding facts and needs of pregnancy, childbirth and child nurture, and the guiding principles of health.

The mother and infant clinics, wherever established, have hitherto secured very much smaller attendances at the sessions devoted to ante-natal care of the mother than at those where the babies are the subject of attention.

Sir George Newman, in his annual report, 1929, admits that the existing ante-natal clinics are in many cases not yet efficient from the medical standpoint. Dr. Veitch Clarke, Medical Officer of Health for Manchester, urges that unless the clinics are able to supply adequate treatment for the morbid conditions found in



their patients, and to arrange for hospital accommodation when required, women cannot be expected to spend their time in visiting them. Mothers of young children often find regular attendances at the clinic difficult to arrange. Some women actively dislike attending amidst a crowd, with the inevitable long wait for examination. Yet to others the clinics are a great source of sympathy and encouragement. They are glad to obtain advice on diet and clothing for themselves and the expected child; they fraternise with the other patients and give their confidence to the woman medical officer usually attached to the clinic, more readily than they would to a man, however sympathetic and competent.

The fact that the services of the clinic are gratuitous, is a substantial recommendation to poor mothers who have no surplus to spend on doctoring. The clinic supplies something of the need left by midwives lacking time or qualifications for ante-natal work; and by general practitioners, who, as a Medical Officer of Health put it to me, dismiss the expectant mother without examination, and a breezy: "You'll be all right, my girl, the baby will be coming along presently." Such facilities as invalid dinners, milk for nursing and expectant mothers, layettes, sterilised maternity outfits, dentistry and dentures, letters admitting to the hospital or the convalescent home, which may be obtained through some clinics, gratuitously, or on reduced terms, are an attraction to poor mothers requiring such aid.

In some quarters it is urged that attendance at an ante-natal clinic should be made a condition of maternity benefit; but even should efficient clinics exist in all districts, compulsion would be neither expedient nor just; it would be deeply resented by a not inconsiderable proportion of insured mothers. Nothing could be sadder or more repugnant to humane feeling than the sight of hosts of unwilling expectant mothers waiting in

queues for examination, and submitting only to avoid losing the needed insurance benefits, for which they and their husbands had been compelled to pay. The present clinics are dealing with but a small minority of pregnant women, who attend only because they find these institutions beneficial. Should masses of women attend from compulsion, the tendency might be for the waiting-rooms to be overcrowded, the waiting objectionably protracted, the doctors overwhelmed by sheer numbers and their interest consequently reduced.

Dr. S. G. Moore, Medical Officer of Health for Huddersfield, took a pioneer lead in advocating the compulsory notification of births, and established first the voluntary, then the compulsory notification in his town before it was adopted by Parliament for the whole country in 1907. He has now established voluntary notification of pregnancy in Huddersfield with remarkable success. Whilst the ante-natal attendances at the clinics in other towns are in the neighbourhood of 5 per cent., already 50 per cent. of Huddersfield pregnancies are notified to the Health Department. Forms of notification are supplied to doctors and midwives, and a fee of 2s. 6d. is paid to them for each notification, if made by the doctor or midwife engaged for the confinement within seven days of the engagement, and provided the consent of the patient to the notification has been obtained. On notification, each expectant mother is visited and examined by an Assistant Medical Officer of Health, a registered woman medical practitioner. A report is then sent by the Health Department to the doctor selected by the mother herself, or to the hospital as the case may be. The Assistant M.O.H. thereafter calls on the expectant mother again and again, to insure that she is under medical care and is following the treatment prescribed. The mother is put in touch with all the services available for maternal aid in Huddersfield. Obstetric consultants are provided where necessary, and

material assistance is obtained from agencies existing for that purpose if required.

Dr. Moore is emphatic in preferring home visitation to the clinic. He writes to me:

“I regard the ante-natal clinic as a method which is convenient to those who serve, and inconvenient and undesirable to those to whom the clinic ministers. The thing should be done the other way round. The paid servant of the public should endure the hardships and inconvenience. The mothers should have rendered to them the needful help in the kindest and most convenient fashion.”

Undoubtedly Dr. Moore is right in principle. The mother should certainly have the option of being examined at home should she prefer it. Moreover, her willingness to be examined and her voluntary co-operation with the physician are essential to the success of any scheme which might be devised. Dr. Moore adds:

“When a mother is too poor to pay for ante-natal or other medical help, the means are available to-day to furnish it to her without cost, and I find that provided the help is tendered in a sympathetic and kindly fashion, without any condescension or other objectionable attitude, it is freely accepted.

“I advocate a Civic Medical Service for Obstetrics.”

Under the voluntary system of notification in Huddersfield, in the years 1916-29, pregnancy was notified in respect of 8,529 women, amongst whom were 21 deaths, a mortality of 2.46 per 1,000 notifications. In the period 1901 to 1929 there were 48,323 births to women whose pregnancies were not notified; 306 of these mothers died in childbirth, a mortality of 6.33 per 1,000 births. In 1928 the maternal deaths in Hudders-

field numbered only twelve, and there was not a single death from sepsis. There were only three cases of puerperal fever. Of the twelve maternal deaths attributed to pregnancy and parturition, only two occurred in institutions, which indicates how much can be done to prevent institutional laxity by vigilant supervision.<sup>1</sup>

Dr. Moore cites two cases showing the advantages of notification and the resultant ante-natal care.<sup>2</sup>

“Case 1.—S.M. Notified under pregnancy scheme by midwife February 2nd. Condition: marked œdema of feet and legs, headache past fortnight; eyesight defective; occasional dizziness; vomiting of pregnancy troublesome. Advice: doctor to be called in at once. February 10: under doctor; better. March 31: confined; healthy, full-time child; placenta adherent. April 11: mother up, anæmic; child well, breast-fed.

“Case 2.—H.M. Not notified under pregnancy scheme. Same midwife engaged. May 8: child born; mother seized with eclamptic fit and died in infirmary; had had swollen legs, acute vomiting, and headache, some weeks before confinement; ‘thought it normal with pregnancy and sought no advice.’”

How many and many another woman has laboured under the same common delusion!

It must be confessed that ante-natal treatment does not always insure results so fortunate as those detailed in the first of these cases, nor are all its statistics so encouraging as those of Huddersfield. In West Ham, where the maternal death-rate, 2·1 per 1,000 births, is one of the lowest in the country, the one mother who

<sup>1</sup> See Chapter III, p. 43 for the high mortality in Glasgow hospitals.

<sup>2</sup> *Proceedings of the Royal Society of Medicine*, 1916, Vol. X.

died of Eclampsia had been regularly and completely examined at the ante-natal clinic up to two weeks before her confinement. No abnormality was discovered, her urine was reported free from albumin. She had no history of previous illnesses. She was admitted to hospital in labour, had five eclamptic fits there six hours after the onset of labour, and died undelivered twelve hours after admission.

It is frequently assumed by medical writers that deaths from Eclampsia may almost certainly be averted by ante-natal care. This case is but one of many which go to prove that the confinement medically anticipated to be normal not infrequently turns out to be the reverse. Dr. Collins of West Ham deduces from this case that "albuminuria of pregnancy can develop with great rapidity, and towards the end of pregnancy frequent attendances for examination should be urged." Yet if further examination or treatment could have saved the patient, either home visitation or earlier admission to hospital was essential; for a mother so far advanced in pregnancy often feels scarcely fit to go to the clinic and wait her turn.

Professor Beckwith Whitehouse insists that toxæmia of pregnancy, leading to death from Eclampsia and other manifestations, may exist without the presence of albumin in the urine. There are warning signs of the disease, but these are only perceptible to the experienced eye—another evidence of the need for specialist medical attendance on pregnant women.

In Glasgow the mortality amongst mothers attending the ante-natal clinics held at the child welfare centres was 6.6 per 1,000 births and the still-birth rate was 3.6 per cent. The abortions were 2.2 per cent. of the total and the premature births 3.1 per cent. A failure rate of 8.9 per cent. apart from maternal deaths. The maternal mortality rate for the city as a whole was 8.79 per 1,000 births and the still-birth rate 4.2 per cent. The Clinics

thus showed a small improvement upon the general average for the city.

The records of ante-natal clinics all reveal that the static condition of bad health and the poor physique of mothers is the great obstacle facing the ante-natal clinic. We may hope that the improved care of infants and children and the consequent lower incidence of rickets and other ills will produce a generation of women better built for motherhood than the present. The Medical Officer of Health for Birmingham reports a growing number of women with pelves above the average size and ascribes this development to more hygienic habits and dress.

Hospitals are now more and more making admission to their maternity wards for all save emergency cases conditional upon attendance at their ante-natal clinics; yet many hospitals have failed to reduce their grievously high rates of maternal mortality. In both hospital and Municipal Clinics the tired mothers who have borne many children and need special care are often left to the midwife, the doctor dealing only with first births. The Maternal Mortality Departmental Committee ascribed 226 maternal deaths out of 1,596 investigated to faulty ante-natal care, failure to make ante-natal examinations, failure to detect gross abnormalities when an examination was made, failure to give efficient treatment when abnormalities were found, lack of institutional accommodation where hospital treatment was needed.

Lady Barrett (Dean of the Royal Free Hospital) recently made an important observation:<sup>1</sup> "I believe that ante-natal work is still in process of growth and it is only those persons who watch cases in labour who gradually realise what are the important things to observe in pregnancy."

The person who makes the pre-natal examination is the person who should attend the patient in labour.

<sup>1</sup> The *Observer*, 10th August, 1930.

CHAPTER EIGHT  
THE SUPREME IMPORTANCE OF  
LABOUR

DOCTOR *v.* MIDWIFE, ANTE- *v.* INTRA-NATAL  
CARE

WHILST the value of ante-natal care must not be underestimated, skilled attention during the birth and puerperium remains of paramount importance, Dr. Eardley Holland, whose researches into the causes of foetal mortality are well known, has uttered warnings against the present tendency to exaggerate the importance of ante-natal as compared with intra-natal care. He has expressed the view that "far more women lose their lives for lack of skilled attention in labour than from lack of ante-natal care." In his *Causation of Fœtal Death* he wrote:

"Ante-natal methods are the strategy, intra-natal methods the tactics of obstetrics. There is, I believe, a tendency nowadays to exalt the strategy at the expense of the tactics. How wrong this unequal conception of midwifery practice is becomes at once apparent when we realise that when treatment is indicated as the result of ante-natal examination it usually consists in the application of intra-natal methods. The only purely ante-natal treatment consists in the treatment of syphilis, and of appropriate cases of toxæmia of pregnancy. Otherwise treatment is by intra-natal methods, such as the induction of premature

labour, Cæsarian section, or the careful management of labour."

On investigating the factors which determined the death of 300 fœtuses of viable age born in various hospitals and infirmaries and at home, Dr. Holland estimated that 52 per cent. of these little ones might have been saved, 20 per cent. by ante-natal treatment (this included 16 per cent. of syphilitic fœtuses), 20 per cent. by better treatment in labour, and 12 per cent. by a combination of ante- and intra-natal care.

An inquiry under the Hampstead Medical Officer of Health, Mr. Scrase, into the causes of still-births covering a period of four years, showed that approximately half were attributable to complications of labour, in which skilled obstetric assistance would have been a great and material help.

The experts and the daily experience of mothers we know alike remind us that emergencies threatening the life of mother or infant may arise, either immediately before or during labour, of which no previous symptoms were apparent, such as ante-partum hæmorrhage, prolapse of the umbilical cord, and prolonged labour, from uterine inertia, persistent occipito-posterior presentation, and other causes. Hæmorrhage after a normal delivery is usually due to mismanagement of the third stage of labour, says Mr. Aleck Bourne, senior obstetric surgeon at Queen Charlotte's Hospital.

Efforts are made to-day to reinforce the widely recognised deficiencies of the midwifery service supplied by private doctors and midwives. The ante-natal and post-natal clinics, and the Health Visitors, calling to advise on the hygiene of pregnancy and the management of the baby, are efforts in this direction, provided gratuitously by the community, irrespective of the means of the mother or her husband. All this is for ante- and post-natal work. For the period of crisis,



where, even in normal cases, there is pain and suffering to an acute degree, where grave and immediate danger to life is always an imminent possibility, where, as Dr. Janet Campbell has it, "delay or a mistaken judgment may cause irreparable damage and there may be no second chance," the community provides no service, nor any aid except for those cases of excessive poverty officially termed "necessitous." For such cases, some Local Authorities provide the fee for a midwife. If the midwife is compelled to call for medical aid, the Local Authority will pay the doctor's fee; but will recover it from the patient or her husband, unless the family is in grossly indigent circumstances. The Maternity and Child Welfare Act of 1918 gave power to Local Authorities to make arrangements whereby a doctor may summon a specialist to his assistance in a confinement, at the cost of the Local Authority. Advantage has only been taken of this power in a few areas. In any case the mother and her husband will be made to reimburse the Local Authority unless they are of the submerged tenth.

*It is only a few far-seeing people who to-day are demanding a National Midwifery Service, locally administered, and free to all mothers. This is of far greater importance than the Health Visitor, and even than the Welfare Centre. Concentration upon this urgent need by even a few ardent people, would soon arouse a wide public movement in its support. There should be a voluntary maternity council to work for it in every district.*

Many proposals for improving the treatment of maternity are now under discussion; but almost all of them are vitiated by the fear of spending enough money to do the adequate thing. Adequate medical attention for all mothers during labour would certainly be costly. Therefore a large proportion of writers and propagandists have persuaded themselves that it is unneces-

sary—a sad solution for a nation in which, as Mr. Snowden the other day informed us, five-sevenths of the national expenditure is for war and military purposes.

Jellett, in pleading for medical supervision of pregnancy, declares that diagnosis is the business of the doctor, not of the midwife, and says of the doctor:<sup>1</sup>

“During the early stages of labour when the diagnosis between normality and abnormality is wanted he is an essential.”

“The responsibility for aseptic technique is his.”

“The date at which a patient leaves her bed is usually a matter for the medical attendant to decide.”

Surely we are not to assume that such admirable maxims are only intended for the welfare of the upper classes!

Professor Louise McIlroy of the Royal Free Hospital has testified, like many a midwife, that in numerous cases of life-and-death struggle four or five doctors have been appealed to before one has been found to attend. The midwife sends for the doctor when the situation has grown desperate; the doctor calls the obstetric specialist when hope is all but gone. The result too often is that, according to medical parlance, “the operation was successful,” but one or both patients died.

Dr. Moore, the Huddersfield Medical Officer of Health, writes in reply to my inquiry under this head:

“Yes: I know of many cases where the mother’s life has been sacrificed owing to the lack of immediate competent medical and surgical help. . . . Not in the interests of the medical profession, but

<sup>1</sup> *Cause and Prevention of Maternal Mortality*, Churchill, 1929.

solely and exclusively in the interests of the patient, I believe that every woman should be attended by a qualified and registered medical practitioner; one does not hear of wealthy people employing midwives. The best is good enough for them, and I see no reason why the best should not be available for every woman on such all-important occasions. Why should the poor woman have to put up with a midwife, who, however skilled, cannot possibly have the training and knowledge of a medical practitioner? It is *not* doctor versus midwife, but mother versus danger; not man versus woman, nor any such question, *only* and *solely* the comfort, welfare and safety of the MOTHER."

I am glad to have the highly competent opinion of Dr. Moore as a support to my own view that a fully qualified registered medical practitioner, man or woman, should be present at every birth, and that the midwife should act as the doctor's assistant. For the medical woman, especially if she is herself actually a mother, this field should be as attractive as it would be wide did all mothers receive adequate medical attention during the ante-, intra- and post-natal periods.

Jellett declares that labour should either be in the hands of a midwife or an obstetric specialist. I would answer that both a midwife and an obstetric specialist, provided by a free municipal service, are not beyond the resources of modern communities, and should be assured as the inalienable right of both mother and child. The mothers cannot afford to pay for the attendance of a trained midwife and a doctor, whether he be an obstetric specialist or not; but the community has the means, and must find them.

It is urged in many quarters that the doctor should be banished from the bedside of the mother in labour,

on the plea that he is apt to interfere too much with the normal course of nature. The midwife is precluded from interference; but the doctor is apt to be overborne, it is alleged, by the importunities of the patient and her family urging him to end her pain, and so hastens the normal process, with results which are bad for both mother and child. The doctor is also incited to hasten by anxiety to proceed to his other patients. Mr. Bernard Shaw<sup>1</sup> is in line with the obstetric experts in quoting his doctor uncle's complaint that certain practitioners make excessive use of the forceps.

It is further alleged that the doctor is a carrier of infection. Obstetric specialists denounce him for his carelessness. Midwives complain that whilst they are under strict discipline in regard to precautions against infection, are suspended if they have come in contact with infectious cases, and are liable to be struck off the register for failure to observe their Rules, doctors can disregard all precautions with impunity. "Oh, the doctor's bag!" exclaimed an experienced midwife, raising her hands in horror and declaring that in many cases, so far from being sterile, its interior is loaded with dust. "I have often seen a catheter brought out of it and passed without any attempt to sterilise," she added. "The doctor's stuffy black clothes," in which he passes from infectious to non-infectious cases, are another source of bitter criticism by the midwife in her clean prints.

Semmelweiss, at the Vienna Maternity Hospital in the eighteen-forties, was faced with this same problem of infection. He saw one in ten of the mothers under his care dying of sepsis, and noted that the mortality was much higher in cases attended by medical students who came from the operating theatre to the lying-in ward, than in the clinic where pupil midwives were trained. His remedy was not to banish the representa-

<sup>1</sup> See p. 182.

tive of Science in the person of the medical student, but to compel him to wash his hands in a solution of chloride of lime before approaching the patient. A year later Semmelweiss had the satisfaction of observing that the mortality had fallen to 1.27 per cent., and that it was lower in the wards attended by medical students than in those where the midwives were trained.

Semmelweiss was hounded out of Vienna by his brother practitioners. To-day his theories have triumphed in every branch of his profession, save in midwifery!

It was strongly urged in the report of the Scottish Board of Health for 1928 that in spite of every possible precaution the doctor may yet become an unwitting carrier of infection:

“It is increasingly believed that the organism which causes puerperal infection is not the ordinary ‘domestic’ microbe of the dirty or squalid house, but is a distinct and virulent form of streptococcus, associated with inflamed and suppurating wounds, and akin to the organisms which cause erysipelas and scarlet fever. The general practitioner is necessarily brought into frequent, and it may be almost hourly contact with these conditions. On occasion he will have to hasten from the dressing of a wound to attend a confinement. No matter how scrupulous his care, how meticulous his surgical toilet, there is danger in this.”

It is widely asserted that there is a higher mortality amongst mothers attended by medical practitioners than by midwives. Having regard to the fact that the majority of the cases in which a doctor is booked are nursed, where not actually delivered, by untrained handy-women, this might well be the case. Yet statistical information on this point has hitherto been meagre.

To arrive at the truth it is necessary to know not merely whether a doctor was present during the confinement, but at what stage he was called. Dr. Janet Campbell, in her *Review of Maternal Mortality*, showed that in Manchester in the year 1922 the maternal mortality was 2·7 per 1,000 births, 60·6 per cent. of the births were attended by midwives, but medical aid was sought by them in more than one-third of their cases. The Medical Officer of Health for Birmingham, in his report for 1928, gives particulars of the attendance in 217 cases of puerperal sepsis in that city. In 82 of these cases a midwife was booked, but in only 57 cases did she effect the delivery unaided.<sup>1</sup>

Most striking evidence in regard to attendance is forthcoming from Aberdeen, where maternal deaths have been systematically investigated since 1917. Drs. Parlane Kinloch, Smith and Stephen have compiled a report on these investigations from 1917 to 1928, which has been published by the Scottish Ministry of Health. Incidentally this report indicates that the maternal death-rate is actually higher than statistics reveal; for one-eighth of the deaths investigated were only found to be connected with maternity by a special census, the death certificates having made no reference to this fact.

In the following table, extracted from the report, the confinements occurring in the ten years have been classified according to the character of the attendance. Cases originally attended by midwives, where medical or hospital treatment became necessary, are re-transferred to the account of midwives; the same is done in respect of doctors' cases sent to hospital. The record of the hospitals is thus perhaps unduly improved; even so it is exceedingly bad. The transferred cases are shown in brackets:

<sup>1</sup> The Maternal Mortality Departmental Committee's investigations showed that out of 470 fatal cases where a midwife had been booked, only 212 were delivered without a doctor's aid.

THE IMPORTANCE OF LABOUR 101

NATURE OF SKILLED ATTENTION AT DELIVERY, OR AT DEATH IF BEFORE DELIVERY, 1918-27 (ten years).

Total births (live and still)—37,984.

Total deaths—252.

	Attendance by			Institution.	
	Doctor.	Midwife.		In-patient.	District.
		Alone.	With medical assistance at birth.		
No. of confinements.	25,013 (1,535)	7,019 (10)	792	2,220	1,372 (23)
No. of deaths from sepsis.	32	6	—	10	1
Deaths per 1,000 confinements (including transfers) from sepsis	1·4	0·85	—	4·5	0·7
No. of deaths from all causes	135 (48)	19 (1)	2	33	7 (1)
Deaths per 1,000 confinements from all causes	6·9	2·8	2·5	14·9	5·6 <sup>1</sup>

It should be observed that the lowest mortality was in the cases shown in the third column, where doctor and midwife were together at the birth, and that amongst these there was not a single death from sepsis. Anxious to know whether in the majority of instances

<sup>1</sup> The higher mortality amongst patients nursed in their own homes from the hospital than amongst patients nursed at home by independent midwives calls for investigation, and indicates a need for greater supervision of cases handled by pupil midwives and medical students.

these were emergency cases, in which the midwife had been compelled to send for the doctor on account of some difficulty, or whether both midwife and doctor had originally been booked, I wrote Dr. Parlane Kinloch<sup>1</sup> for his opinion on this point. He replied:

“In only a very few of these cases was this double attendance prearranged. In the vast majority of such cases the attendance of the doctor was due to emergency.”

The fact that even in these difficult confinements, where the mother might be expected to be specially vulnerable to disease, deaths from all causes were lowest and mortality from sepsis was absent when doctor and midwife attended together, militates against the theory that the doctor is the carrier of the disease.

The question insistently rises: who nursed the twenty-five thousand doctors' cases recorded in the first column, amongst whom thirty-eight mothers died from sepsis and there was a total mortality of 183, or 6.9 per thousand confinements?

I was morally certain that the attendant was a poor handy-woman, often elderly, always untrained; a char-woman, rising from her scrubbing and wiping her work-worn hands upon her apron as her preparation for attendance upon the mother and child; a neighbour snatching some moments from her household work; a relative, or any other untrained woman able to give some partial attention to the case. I was not wrong. Dr. Kinloch informs me:

“It can be accepted that in the vast majority of cases nursing attendance was provided by an untrained relative or untrained handy-woman.”

<sup>1</sup> Medical Officer of Health for Aberdeen when the report was compiled.



The quality of the nursing is of first-class importance in every illness, not least in childbirth. The midwife gives at least some modicum of nursing to her patient; the doctor gives none. His obstetric task may have been skilfully done, with every aseptic precaution; but if the mother is left thereafter in the hands of an untrained woman, his care may prove in vain. Moreover, he will be apt to observe, and to insist upon more completely aseptic conditions where a trained midwife is the attendant.

Again, we must remember that it is unfortunately the handy-woman who actually effected the delivery in many so-called doctors' cases.

The writers of the report have ascertained that medical assistance was obtained in 1,084<sup>1</sup> out of 7,715 midwives' cases, and that in 445 of these cases the forceps was used. *There were no deaths among these cases.* The writers of the report argue that this success was due to the fact that the doctor, summoned late, was not able to use the forceps too soon, and that it is the improper use of forceps to expedite delivery, which is "responsible for trauma, with ensuing sepsis in the practice of doctors."

I am unable to accept the view, advanced in this report and elsewhere, that the alleged carrier condition of doctors would be "nullified" were they only called in for obstetric complications. If they are really a serious source of infection, they should be barred from the lying-in room altogether. Instead of admitting them to the complicated cases most liable to fall victims to sepsis, they should be replaced by specialists in midwifery, upon whom would be laid the duty of keeping themselves free of infection.

The conclusion that the 6.9 per 1,000 mortality amongst doctors' cases was due to the premature use of

<sup>1</sup> Medical aid was sought for 112 cases during pregnancy of whom one died; 793 cases during parturition of whom two died; 179 cases after parturition, of whom fifteen died.

the forceps is a drastic condemnation of the medical profession which I should be loth to make. I am inclined to believe the facts fail to justify it, and that the relatively high death-rate in the doctors' cases was in large part due to two causes; firstly, the lack of skilled nursing; secondly, that the more difficult cases, especially those in which the mother was ordinarily a sufferer from bad health, booked a doctor for the confinement. The investigators report that 34 per cent. of the women who died had had bad health before pregnancy, whilst the health of 56 per cent. had been unsatisfactory during pregnancy.

The theory that the doctor is the carrier of infection is elaborated at length in the report. It is argued that puerperal fever is mainly caused by a micro-organism known as streptococcus hæmolyticus, the "normal habitat" of which is the human throat. In the practice of their profession, doctors are, of necessity, repeatedly exposed to spray or droplet streptococcal infection, and may be assumed to have developed the degree of immunity necessary to the true carrier condition. It is assumed that the carrier physician sprays streptococci from his throat and nose on to the sterilised hands and instruments, which infect the maternal passages. The theory that infection is conveyed in this way has been gaining ground in medical circles for several years. On this assumption, any person who enters the lying-in room may be a possible source of infection. In Glasgow, in 1928, seventeen midwives had two cases of puerperal fever in their practice, five had three cases, two had four cases and two had five cases.

As to ophthalmia neonatorum, eighteen midwives had six to ten cases, six midwives had eleven to fifteen cases and two had actually from twenty-one to twenty-five cases, in spite of the regulations to control infection governing the practice of midwives! Similar information if given for doctors might yield illuminating results.

To the mothers it would be valuable if the record of the attendant they propose engaging for their confinement or the institution they propose to enter could be known to them.

Largely under the inspiration of Dr. Parlane Kinloch, advisor to the Scottish Department of Health, a systematic attempt is being made at the Elsie Inglis Memorial Hospital in Edinburgh to discover and eliminate the sources of puerperal infection. In this hospital the morbidity rate during four years was 111 per 1,000 confinements, the rate of puerperal fever 17, and the total mortality 8.9 per 1,000 confinements. Though lower than in many Scottish hospitals, these rates were unduly high. From December 1st, 1929, a new routine was introduced and a full-time bacteriologist engaged. Swabs are now taken from the throat, vagina and cervix of patients at the ante-natal clinics six weeks before the confinement, and again from the throat and vagina two weeks before the confinement. If hæmolytic organisms are there found, the patient is treated until negative, and if the organisms persist, she is isolated on admission to hospital. Throat swabs are taken periodically from all members of the staff, doctors, sisters, nurses and ward maids. Those found to carry hæmolytic streptococci are sent off duty until negative. If they are not negative within seven days they are regarded as carriers and advised to have their tonsils out and other treatment. The nurse who prepares the patients for admission to the labour ward wears a mask, and all nurses and doctors entering the labour wards wear masks, clean gowns and leggings. All who attend the patients wear sterile gowns, masks and gloves. Very gruesome all this doubtless appears to the uninitiated patient. It is early yet to pronounce upon the result of this routine. Up to March 31st, 1930, there had been 268 confinements under its auspices, of which 26 reached morbid standard, the same obstinate

10 per cent. which afflicted the old building started by Elsie Inglis in the High Street before it moved into the new and spacious building. There were two deaths under the new routine, but both the patients had suffered from gonorrhœa and other pre-natal morbidity.

In 1928 the Ministry of Health decided to organise an investigation into all maternal deaths through the local Medical Officers of Health, on a voluntary basis. The request of the Ministry has not been responded to in every case, though the inquiry is wholly confidential; the names of the medical practitioners and midwives concerned are not sent to the Ministry, which has pledged itself not to use the facts revealed as a basis for criticism of those who attended the deceased.

Jellett, who, as Obstetric Consultant to the New Zealand Government, is daily dealing with the same problem, protests that "criticism is essential," for medical education has been, and is, insufficient. Taking his work with commendable seriousness, Jellett makes it his business to get into touch with the hospitals and medical practitioners concerned in all New Zealand cases where the nature of the case, or the ultimate result, suggest to him that advice or criticism, based on his wide experience and knowledge, might be helpful. He claims that by systematic advice and criticism he is raising the standard of midwifery in New Zealand.

Mr. F. E. Scrase, F.R.C.S., Medical Officer of Health for Hampstead, has advocated an inquest on every woman who dies in pregnancy or childbirth. My own view is the same. Investigation of all the circumstances attendant upon the death is of the highest importance, and should include the information which can be supplied by those who were familiar with the conditions of the dead mother's life, as well as by those whose duty it was to attend her professionally. To make a mother's death in childbirth the subject of a public inquiry would

educate both the medical profession and the public at large.

The form of inquiry into maternal deaths which the Committee on Maternal Mortality established by the Ministry of Health has circulated under the instructions of the Ministry, emphasises rather the final than the predisposing cause of the fatality. The questions asked and the space allowed for reply in relation to the economic condition of the mother, the work she did, and the state of her health during pregnancy, are somewhat meagre. They should be amplified. It is unfortunate that the Committee actually suggests to Local Authorities that they may desire to vary the inquiry form, for unless all local inquiries obtain the same particulars, statistics large enough to be useful cannot be obtained. The interim report of the Committee reveals the unsatisfactory results of the permissive and indefinite character of the inquiry. Even yet only about two-thirds of maternal deaths are investigated, and the information received by the Committee is lacking both in accuracy and extent. Out of 1,596 deaths due to pregnancy and childbirth 188 were not strictly relevant to the inquiry, in 122 cases the information supplied was insufficient for the Committee to form any opinion as to how the fatality might have been averted, and 626 cases showed a primary avoidable factor. In 660 cases no departure from established practice to which the death could be ascribed was found, but the Committee stated emphatically that its failure to find such a fault was probably due to the deficient information supplied.

Of the 626 deaths which ought to have been averted 226 were due to lack of ante-natal care, 224 to errors of judgment by doctor or midwife, 62 to lack of facilities for treatment. Only 112 could be ascribed to the patient's own negligence.

This is a terrible indictment of present-day mid-wifery!

## CHAPTER NINE

### ABORTION

THERE is undoubtedly a great international tendency towards the limitation of families. Abortion, a terrible and dangerous expedient, is appallingly common amongst married women. Frank Cook of Guy's Hospital says: "The artificial termination of pregnancy, whether therapeutic or criminal, is naturally more prone to fatal or morbid issues than is spontaneous abortion," and even under the best conditions, and with every aseptic precaution, its difficulties and dangers are considerable. Dr. Moore of Huddersfield writes:

"I wish it could be made known to the widest extent that there is no drug in a pharmacopœia, or out of it, which can be relied upon to evacuate the pregnant uterus, except at the cost of imperiling the life of the mother."

Whether induced by instruments, by drugs, such as lead, by drastic purges, or by other methods, it is followed in an occasional sad case by sudden death from shock, or by septic infection, or hæmorrhage which proves fatal. Some of the fatalities arising from it never come to light in their true colours. The full tale of the numerous cases of serious or minor illness caused by abortion will never be known. Dr. Comyns Berkeley urges that much maternal misery and illness would be saved if the notification of abortion were made compulsory, in order that its effects might be treated; but obviously whilst abortion remains a criminal offence it will always be concealed if deliberately induced, and

there will be a certain amount of hesitation in disclosing it, even if it has happened spontaneously.

In the many cases which occur through ill-health or over-exertion the woman usually takes no more notice of the event than her condition literally compels. Serious bleeding or sepsis may drive her to bed, or to the doctor; but mild sepsis is generally ignored. Dr. Comyns Berkeley says:

“The morbidity due to abortion may result in a further infection in a succeeding birth from old uterine infection.”

He adds that injury and sepsis are more common in artificially induced than in natural abortion, and estimates that 18 per cent. of abortions are accompanied by fever in a greater or less degree. In 1911 there were 239,000 known abortions in Germany, 23,900 of which were infected. The numbers have enormously increased since that time.

Investigations by the United States Children's Bureau revealed that 42 per cent. of the maternal deaths from sepsis in seven States followed abortion. In Nebraska less than half the maternal deaths succeeded the birth of living children, and a quarter succeeded abortions.

Numerous indeed are the married women in this country who, under economic pressure and the strain of maintaining the welfare of their families, have attempted abortion, not once but many times. “When I found I was pregnant again I tried everything!” How often the phrase slips out when a mother is telling her troubles to sympathetic ears! A woman who to-day is a Borough Councillor, with children already old enough to share her social work, came to me years ago in a pitiable condition; she had doubled and doubled daily doses of Beecham's pills, till she was swallowing thirty-two at a sitting, and had reduced herself to a state in

which she was scarcely able to sit in a chair; yet had failed to attain her object.

"What shall I do now?" she wailed, looking to me to find some exit from her dilemma.

"Now we shall have to get you made better to have the baby," I answered, Nemesis-like, perhaps, to her ears; yet the lad has done well; she is proud and glad of him now.

Mothers vehemently defend abortion, declaring that they have resorted to it for the sake of their children. Increasing numbers of people argue that, faced with undesired pregnancy, women will procure abortion by hook or by crook; therefore the law should permit abortion, provided it be done under State supervision, with strict aseptic precautions. Others consider that since even under the best conditions abortion is injurious to the mother, it should be avoided by preventing pregnancy, and that the use of contraceptives should be publicly taught under Government auspices. Both views have received legislative sanction in Soviet Russia, which in this, as in much else, has become a field of experiment in social theories.

It is grievous indeed that the social collectivity should feel itself obliged to assist in so ugly an expedient as abortion in order to mitigate its crudest evils. The true mission of Society is to provide the conditions, legal, moral, economic and obstetric, which will assure happy and successful motherhood.

The Soviet Government states that the number of abortions in the R.S.F.S.R. in 1927 was upwards of 201,480; that illness following abortion which had been 19.9% dropped to 4.75% in 1921-23 after abortion was legalised. The number of abortions in towns is 35% of the total births; from 53 to 55% of abortions are interrupting a fourth pregnancy. In the towns the majority occur between 20 and 29 years; in the country over 30 years.



## CHAPTER TEN

### THE WAGE-EARNING MOTHER

STATISTICAL inquiry into the incidence of mortality and morbidity amongst mothers in various employments has as yet been too tentative to provide reliable evidence of its effects; but every woman knows that if she has the double burden of earning the family income and working in the home, with all that includes "mothering," she has more to do than she should, and is always tired and distraught by the effort to accomplish the impossible. The home is necessarily uncomfortable for all concerned. She gets too little sleep and is forced to neglect herself in numberless ways. The well-to-do woman little realises how much greater is the amount of time she spends in eating, sleeping and dressing herself, washing her body and attending to her hair, skin, teeth and nails—to say nothing of buying her clothes and amusing herself—than is possible to the poor working mother.

Robert Morse Woodbury's report on maternal and infant mortality in eight American cities showed that premature births and maternal and infant deaths are most frequent amongst mothers employed away from home; least frequent amongst mothers gainfully employed in the home. The rate of mortality and premature delivery amongst mothers employed only in their own domestic work was lower than amongst those working outside the home, but higher than amongst those engaged in paid home-work. Such figures reveal little in the absence of information on many attendant

circumstances. Nevertheless, the indication is obvious that the strain of keeping up the pace of factory or other outside employment is too great for a pregnant woman. The woman employed at home, though spurred by her need, is not under disciplined compulsion to continue beyond the point of endurance. One may hazard a guess that the mothers wholly employed in their own house-work were the possessors of the larger families, who had more heavy housework to do than those who took in paid home-work. The high maternal mortality rate in the Lancashire textile areas points in the same direction.

It is a necessity of pregnancy that the mother should have abundant rest and fresh air, and that her employment should be light and varied. To sit the greater part of the day at a typewriter or a sewing-machine, to stand at the mangle and wash-tub till her back aches, to toil round the streets as a canvasser, or to trot about working in her own house till her feet burn and her legs swell are obviously bad for her and for the child. The fact that her grandmother did it, and suffered under it, is no answer to this contention.

The nursing mother is in like case; to do well by her baby, and to maintain her own health, she needs leisure and rest, and relief from all excessive strain. The Washington Draft Maternity Convention, agreed to by the British Government representatives in 1919, but never ratified by our Government, declares that benefits shall be paid to the mother sufficient for the full and healthy maintenance of herself and child during the six weeks preceding and six weeks following the confinement, and that on resuming work she shall be allowed two half-hour periods a day in order to suckle her baby. These proposals, which have been adopted wholly or in part by several countries, including France, Russia and the Scandinavian countries, are small indeed in comparison with actual needs. If they appear an acceptable

minimum to any mother, it is only because her present position is much worse. Nevertheless, the proposals were rejected by the Government of the day because its actuary, Sir Alfred Watson, reported that it would cost the Exchequer £1,700,000 per annum—a mere trifle as compared with our vast naval expenditure.

The Factory and Workshops Act of 1901 merely provides that a woman wage-earner may not return to her employment within four weeks after the birth of her child; but in the absence of maintenance for her during that period, the Act is to a large extent a dead letter.

The National Health Insurance Acts provide maternity benefit of £2<sup>1</sup> towards the cost of the confinement. Even where maternity benefit can also be drawn in respect of the husband's insurance, £4 being thus available, the sum obviously does not compensate for the mother's loss of earnings. It fails to cover the special expenses entailed by the birth.

It is a remarkable and sad fact that the mother in her confinement gets less aid from the British National Insurance than a person suffering from any illness unconnected with childbirth, however slight. If her sister or brother has a sore throat, an influenza cold or any other ailment which the doctor will pass as necessitating absence from work, sickness benefit of 15s. a week for the man and 12s. 6d. for the woman is payable up to 26 weeks, and thereafter 7s. 6d. disablement benefit. The mother gets only the maternity allowance, which, after all, is merely the equivalent of 10s. a week for four weeks. During the four weeks following the birth, even if she contract puerperal fever, or other serious illness arising from her condition, she is entitled neither to monetary nor medical sickness benefit. She must provide doctor, nurse, medicine and hospital treatment for

<sup>1</sup> Some approved societies increase this by about 2s. to 5s. or thereabouts.

herself as though she were not insured. Motherhood and womanhood as a whole were at a discount when the National Insurance Acts were passed. Even yet they are far from taking their rightful position in the estimate of Governments and of the community.

CHAPTER ELEVEN  
THE UNMARRIED MOTHER AND  
HER CHILD

THE infant death-rate for England and Wales has fallen from 90 per 1,000 births in 1917 to 65 per 1,000 births in 1928; but the death-rate of children born out of wedlock, which in 1917 was 201, in 1928 was still 194 per 1,000 births. In "healthy" Hampstead the death-rate for children who are termed "legitimate" was only 35 per 1,000 births, whilst the death-rate of the poor little "illegitimates" reached the enormous total of 278 per 1,000 births.

Do the inhabitants of the pleasant villa residences in the garden suburb ever realise that more than a quarter of those little neighbours of theirs, the tiny British outcasts, open their eyes on life only to close them in the sleep of death before a year has passed? In Hackney the tale is yet more grievous; the mortality of the outcast infants was 331 per thousand births; at Canvey Island in Essex, 400 per 1,000 births; at Malden the awful total of 555 deaths per 1,000 was reached<sup>1</sup>—a veritable holocaust of the innocents!

What is the cause of it? Syphilis? No; sheer poverty! These figures from Brighton are illuminating: infant mortality amongst the well-to-do, 60 per 1,000 births; amongst the artisans, 87 per 1,000 births; amongst the unskilled labourers, 103 per 1,000 births; amongst the unmarried mothers, with their low wages and double load of anxiety, 133 per 1,000 births. On the social ladder theirs is the lowest rung, and they and

<sup>1</sup> The death-rate of legitimate infants in Malden was only 36 per 1,000 births.

their infants suffer accordingly! Just as the mortality of their children is excessive, so is the mortality and morbidity among these most unfortunate mothers. In Aberdeen, during the years 1918-27, special investigations showed that the death-rate of unmarried mothers was 13.2 per 1,000 births, as compared with 6.0 per 1,000 births amongst married mothers. The major causes of death showed the following rates:

## DEATHS PER 10,000 BIRTHS

	Sepsis.	Abortion, septic.	Abortion, non-septic.	Albumin- uria.
Unmarried . . .	36	18	12	33
Married . . .	12	2	3	9

Dr. Robert Lyster, County Medical Officer of Health for Hampshire, has spoken out boldly upon the handicaps placed upon the unmarried mother:

“The obvious hardships encountered by the average unmarried mother, together with the atmosphere of hostility and desire for punishment which so commonly surrounds such cases, is quite sufficient to explain the whole of the extra mortality and damage. All these differences would tend to disappear if the unmarried mother had fair play. . . .

“In a certain town, well provided with charities and endowments, some of which are expressly for the purpose of providing help for pregnant women during their confinements, there was a general combination against the unmarried mother, who was jealously excluded from all privileges of this kind. The Local Maternity Society refused to allow their midwives to attend her, and she was excluded from all benefits in every possible way,

so as to force her to take refuge in the Poor Law Infirmary, or in the local Refuge Home. Some of the results of this cruel treatment reached the ears of the Medical Officer, and he was supplied with a list of cases who had been refused any attention by the Maternity Society, and where death or illness of mother or child had resulted from neglect. Acting upon the strong recommendation of the Medical Officer, the Local Authority provided in that area a midwife to attend gratuitously such poor cases as were refused by the Maternity Society, a provision obviously necessary in the interests of public health. This provision seemed to be, in fact, merely a very simple necessity from public health points of view. Locally, however, there was an immediate uproar. The scheme was attacked and, as is usual in such cases, unscrupulous misrepresentations were made about it. In such cases it is curiously common to find that the morality which is called truthfulness is sacrificed in what is considered to be the interests of other kinds of morality. A letter signed by seven clerics (one rural dean, two vicars, and four rectors) was addressed to the Chairman of the Local Authority protesting against the appointment of the midwife 'as likely to give a stimulus to immorality.' The attack was partially successful and the midwife was withdrawn. The case serves as an excellent illustration as to the extent to which the ancient and evil desire for punishment still pervades the subject and prevents effective action.

"Welfare Centres now constitute part of the general public health policy of the country, and are doing wonderfully successful work everywhere, but in many of them the unmarried mother is either not welcomed or is made to feel her position. . . . Quite commonly all help is refused, except on

the condition that the woman enters an institution, and all sorts of devices are used to force the unmarried mother into institutional life. . . . This kind of segregation is, generally speaking, wholly bad. The great hope of success in such cases lies in keeping up at all costs the normal home life, and institutions should be a last resort. . . .

“For the past fourteen years, strenuous efforts have been made to apply the Mental Deficiency Act, 1913, to the unmarried mother in order to secure her segregation in an institution. I am speaking from personal experience when I say that very severe pressure has been, and is being, brought to bear upon certifying officers under the Mental Deficiency Act to certify unmarried mothers as coming within the scope of the Act, although their mental condition may not in any way fulfil any of the definitions of that Act. Certain cases which I have been pressed to certify under the Act, but which I have judged to be entirely outside that Act, have eventually been certified elsewhere and have been segregated in institutions for mental defectives. From this personal experience I think it probable that large numbers of unmarried mothers are in institutions for mentally defective persons and are being kept there at the public expense, probably for the remainder of their lives, although the justification of dealing with them under the Mental Deficiency Act is, to say the least of it, extremely doubtful.”

The Poor Law debarred the unmarried mother from outdoor relief and her child from admission to the Guardians' cottage homes, unless the mother were a workhouse inmate. Many hospitals discriminate against her, or admit her only when she is willing to appear as a penitent and is the mother of a first child.



My friend Lilian Woolf, who, as a philosophical Anarchist, disapproves the legal marriage, was refused admission to the Royal Free Hospital for the birth of her only child, on the ground that, as she was still cohabiting with her child's father, she was not a "deserving case." At Queen Charlotte's married women must produce their marriage certificates, "deserving single women are admitted with their first child only."

The unmarried mother, a young domestic servant, as she so commonly is, comes out of the hospital or work-house infirmary, trembling with weakness and hardly able to carry the baby in her arms. Too often she is penniless and has nowhere to go. What is to become of her? In France or in Denmark some small allowance would be made to her for a few weeks to enable her to find her feet. Here she may look in vain for a helping hand unless she is prepared to enter an institution, which may seem to her a virtual imprisonment.

I have many times had one of these girls brought to me either before or after the confinement. Once it was a park keeper who found the girl fainting in Victoria Park and brought her to my house, close by in the Old Ford Road; sometimes it was a passing pedestrian who saw the girl sinking from exhaustion, sometimes a neighbour or friend. Once it was the mother of a girl of seventeen, whose husband had forbidden their daughter the house, and who came to me in her helpless economic dependence on him, pleading for help.

From time to time I have had a host of letters from unmarried mothers, and many I have known personally, struggling to keep in touch with their children under adverse conditions and displaying in full measure the normal love of normal mothers and their yearning to do well by their little ones, and to see them grow up in health and happiness as the light of their eyes and the joy and inspiration of their lives. I have learnt from them the ignominies they have suffered, the hard tasks

heaped upon them, and their meagre pay; for everywhere advantage is taken of the social contempt in which they are held.

The Maternity and Child Welfare Act of 1918, if it were fully applied, could aid substantially in reducing to the general level the excessive mortality amongst the children of such forlorn young mothers; but the fear of "encouraging" their condition militates against applying the provisions of the Act to those whose need is greatest.

The law of this country still debars the child born out of wedlock from inheriting from anyone, even the mother, except by a will made in his favour; for a bastard is still legally *filius nullius*, the son of no one. This is a blot on the Statute Book, but for the vast majority of these children and their mothers there is no possibility of inheriting a copper from anyone; it is a question whether the mother will be able to earn the bare essentials of subsistence for herself and her child. In France, in Scandinavia and Russia unmarried mothers and their children are treated with a larger share of justice and humanity than is the case here, though the French law in some respects grievously calls for amendment.

## CHAPTER TWELVE

### A NATIONAL MATERNITY SERVICE AND BOUNTY FOR MOTHERHOOD

IN the eighteen 'sixties and 'seventies our fathers were agitating for universal free education. It was a bold thought at that period; but to-day the elementary school pence have long joined the almost forgotten lumber of the past, and no one questions either the value or the justice of free elementary education.

Even had we not a high and obstinate maternal mortality rate, which has entailed the loss of more than thirty thousand mothers in childbed during the last ten years, it should not now be difficult to rouse the public conscience to the necessity of an entirely free and efficient maternity service open to all. The mother, who with mortal risk and pain gives a new citizen to the community, is entitled to this aid. The first and most essential service Society can render to its children is to insure that they shall be rightly born, and protected by every known safeguard from birth injuries and infections. The upkeep and lighting of the public roads, the protection of property, and all the other innumerable public services are of lesser importance than this first need.

Though the situation is befogged by a prolixity of discussion on insurances and income scales, and the ramifications of the present unco-ordinated and insufficient, yet overlapping, arrangements, the need for an all-embracing free service is steadily making itself felt.

To any who protest that the nation would have diffi-

culty in financing an adequate Maternity Service, one must reply that the pioneers of universal free education met and vanquished the same financial objection, at a time when the general view of the mutual obligations of the community and its members was infinitely narrower than to-day. We may point also to the widespread desire to reduce the vast expenditure on armaments, and urge that the money thus saved on engines of destruction should be diverted to the high service of life creation.

The National Maternity Service should be available to all mothers here resident, on the principle embodied in the Australian Maternity Allowance as established in 1912. Children born of foreign parents on British soil are British subjects according to British law, and were called up as conscripts during the late war.

Approximately 670,000 confinements take place in England each year; by no means an impossible number to be financed by so wealthy a country as this. The Government Actuary estimates that the 40s. maternity benefit provided by the National Insurance Acts is payable in 80 per cent. of the whole number of confinements. Amongst the 20 per cent. of mothers who get no benefit, some 70,000 are in an economic position no better than that of the insured workers.

It would be a mistake to exclude from the National Service the people temporarily out of benefit, whether through unemployment or other causes, and the non-insurable workers, amongst whom are included the poorer professional and trading classes, and many people who are even less able to make proper provision for maternity than the insured wage-earners. The uninsured should not be relegated either to private charity or to the haphazard and insulting method of special provisions for "the necessitous," with their inquisitorial investigations of income and punitive provisions, which necessitate costly additions to official staffs, placing a

## NATIONAL MATERNITY SERVICE 123

premium on subterfuge and deterring the sensitive from applying for gravely needed help.

I have before me the forms at present used in maternity and infant welfare work by some of the Borough Councils. At the head of one of them is printed in bold red ink a warning:

**"ANY FALSE STATEMENTS MADE WILL RENDER THE APPLICANT LIABLE TO PROSECUTION.**

**"ANY PARTICULARS WITHHELD WILL DELAY THE GRANTING OF MILK.**

**"ALL PARTICULARS WILL BE INVESTIGATED."**

Below are demanded the name and address of the husband's employer, or last employer, the husband's works number, his wage, and the proportion of it contributed towards the family expenses; the same particulars for the children or others in the family who are at work, whether any war pension, unemployment benefit, Poor Relief or other income is received by anyone in the family, what is the rent paid by the applicant, the total rent of the house, what lodgers there may be, and what rent they pay. The children's names, date of birth and birth certificates are also demanded, and the Council takes no responsibility for the loss of certificates. The forms from other Councils are similar. One of them asks for the name and ticket number of the husband's foreman, which means that not only the employer but also the foreman will be interrogated.

### A NATIONAL MATERNITY SERVICE

A National Maternity Service should establish:

(1) *A Maternity section of the Ministry of Health and the local Health Departments.*

The Maternity and Infant Welfare Centres, one of which should be in each district, would be tributaries of the Maternity section, where mothers could obtain advice at any time and apply for the various services attached to the Maternity section. The present Mothercraft lectures would be continued there for those who desire them, as well as the baby-weighing, though the weighing could, and should, be done, and all needful information should be given by the Health visitor where the mother is not an attender at the centre.

(2) *A staff of fully qualified medical practitioners, who have specialised in obstetrics and Gynæcology*, should be attached to the Maternity section, in number sufficient to deal with all the confinements in the area, as well as to provide ante-, intra- and post-natal care for every mother.

*The attendance of a qualified medical practitioner at every birth should be made legally compulsory.*

(3) *Consultants to be called to cases of special difficulty*, whether attended by private practitioners or by those attached to the Maternity centre, should be included in the Maternity Service staff, which should, in fact, be available for all maternal emergencies.

(4) *A staff of registered midwives holding C.M.B. certificate* to assist the medical practitioners and nurse under their directions. Nursing by a registered midwife should be compulsory in all confinements, the untrained and unregistered assistant or handy-woman being wholly eliminated.

(5) *A staff of trained "Home Helps."*

(6) *Maternity Homes* or hospital treatment for all mothers desiring or needing them.

(7) *Sterilised maternity outfits* for all confinements provided cost free by the Health Department.

(8) *Convalescent Homes* to enable all mothers willing to avail themselves of this advantage to recuperate after confinement.

## THE MOTHER

Every woman notifying her pregnancy to the Health Department would be visited by a doctor (preferably a woman doctor) from the Maternity section, who, with her consent, would examine her and prescribe such treatment as might be necessary, and advise her in regard to her health, diet, clothing and the hygiene of pregnancy in general; and would consult her as to the preparations she should make for her confinement, whether the birth should take place at home or in hospital, whether a home help would be required, and how the children should be cared for during the confinement.

The doctor would thereafter keep the expectant mother under care, calling on her at the periods appropriate to her condition, during the last period weekly, and taking the necessary measurements and observations by all the methods known to obstetric science, including the X-rays. On some occasions the doctor would be accompanied by the midwife, who would assist at the birth and would nurse during the puerperium.

The doctor who had treated the mother ante-natally would be in attendance at the birth and would visit her throughout the confinement, making a complete examination at the close of the puerperal period, and keeping both mother and infant under treatment and observation until both should be in normal condition. Should hospital treatment be required at any stage, the doctor would arrange for it.

The doctor would be assisted by a registered midwife supplied by the Department, who would nurse the patient under the doctor's directions.

The doctor would be wholly responsible for diagnosis and prescriptions, for the administration of anæsthetics,

sedative, ecboic and other drugs, and for operative procedure.

The midwife would give full-time daily attendance for twenty-one days, or for such longer period as the doctor might certify to be necessary in the interests of mother and child.

Night nursing would be provided, as required, by a relief midwife from the Maternity section.

A home help would be supplied on the application of the mother or her representative, for approximately two weeks before and six weeks after the birth; these periods to be extended on the certificate of the doctor that the patient requires whole or part-time assistance for a longer period on account of her condition.

Home helps would be supplied on request during the absence of the mother in hospital or convalescent home, whether on account of maternity or otherwise, and should attend, after the mother's return from the institution, for a minimum of six weeks after the birth and as much longer as the doctor might consider necessary. A service of women to wash and clean for pregnant mothers is even more reasonable and necessary than the present service of garbage collectors. The average mother is unfit for the entire work of a household for at least six weeks after the confinement, and many women are unfit for a much longer period.

*Maternity Home and Hospital* accommodation free of charge to the patient should be available, as part of the National Service, for all women desiring it, and for those whose condition renders institutional treatment necessary.

The dangers at present menacing the lives of maternity patients in some institutions should be rigorously eliminated, and the strictest aseptic precautions enforced. Wards should be steadily superseded by separate rooms in all maternity institutions. The fact that prisoners, whether in the prison hospital or not,



are usually provided with separate cells, whilst mothers are herded together in wards, makes a curious commentary on current social usages.

*Convalescent Homes* should be established in the country, and every mother willing to go should have a month's rest free of charge there, as soon as sufficient homes can be provided. A big appeal should be sent out to owners of great country residences to accelerate the attainment of this ideal by presenting a house to the nation. If every mother and baby could have this boon a great source of well-being would flow into the national life.

#### THE NOTIFICATION OF PREGNANCY

The notification of pregnancy by the mother, whilst entirely voluntary on her part, would take place automatically on her application for the various departments of service and benefit provided by the National Maternity Service.

Should the mother prefer to engage a physician in private practice for her confinement, it would be his duty to notify the Health Department on his engagement by the patient. The mother would then be visited by the Maternity Service and informed of her right to be examined by one of its obstetricians. Should she desire such examination, the report of the obstetrician on her case would be presented in duplicate to the patient and to her own doctor. As in Huddersfield, the physician of the Health Department would thereafter call as often as necessary to ensure that the mother was receiving any treatment required.

#### FREEDOM OF CHOICE

The patient desirous of obtaining a doctor, midwife or home help apart from the National Service would be perfectly free to do so, provided the persons of her choice possess the necessary qualifications. They

would be bound by the same midwifery rules and subject to the same inspection as employees of the National Maternity Service. Their fees would be paid by the Health Department on a standard scale, without charge to the patient.

The proportion of cases in which private practitioners were chosen would be a criterion of the popularity of the National Service. A genuinely efficient National Service would shortly secure the vast majority of the patients, if for no other reason because of its all-embracing character.

#### MIDWIFERY RULES

Medical practitioners, midwives and home helps, whether in private practice or members of the National Service, would be subject to medical examination as well as fulfilling the necessary standard of training, and would be bound, in their respective spheres, by a body of Rules established to safeguard maternity and infancy, drawn up by an obstetric council, which might be composed of representatives of the Ministry of Health, the British Medical Association and the Women's Medical Federation, the College of Obstetricians and Gynæcologists, and the Central Midwives' Board, or a body more directly representing the associations of midwives and those which would be formed of home helps.

*A Report of each Maternity Case* should be provided by the doctor in attendance, and registered with the birth<sup>1</sup> for use in subsequent confinements.

*Sterilised Maternity Outfits* would be supplied free of cost by the Health Department for all births, and the use of approved sterilised outfits would be compulsory. Already a few Local Authorities supply such outfits, either free or at cost price. Birmingham supplies a large outfit for 6s. 2d. and a small outfit for 3s., but only 188

<sup>1</sup> This suggestion is made by Jellett.

of the former and 37 of the latter were purchased in 1928. The importance of sterilisation is not yet understood. People of slender means find the confinement too costly already to be willing to spend money on extras they imagine unnecessary.

In all confinements a private doctor, or the midwife in his unavoidable absence, or the relatives of the patient, should be entitled to apply to the Maternity Service for medical nursing, or home help relief, or institutional treatment for the patient in case of need.

#### THE MEDICAL PRACTITIONER

The doctors of the Maternity Section, employed at a regular salary and pensioned at the close of their service, would be chosen for their special interest in obstetrics, and would gain in knowledge and experience by reason of their specialised service. It should be a part of their duty to keep abreast with the times in their profession, to attend lectures and demonstrations by experts, which would be arranged by the Health Department to promote the efficiency of the Service and to co-operate in the researches undertaken by the Health Department, in the effort to render childbirth as safe and painless as possible, both to mothers and infants.

Attendance at refresher courses, which would be included in the work of the practitioners of the Health Department, would be obligatory also for private practitioners, who would be indemnified for their losses during such attendance.

Midwifery would speedily pass from the hands of the general practitioner to the specialist. Though his fees would be paid by the Health Department, the specialist in private practice would only be able to secure patients by giving at least as efficient a service as that provided by the Department itself.

## THE MIDWIFE

The midwife should be trained cost free, as in Sweden. The three years' training insisted upon in Holland, or a full hospital training, with an additional year or eighteen months in midwifery, ought not to be too much for this country to afford. After obtaining her certificate of registration the midwife would work for a year as an assistant.

Every midwife should be expected to take a course of a week's theoretical and practical instruction from obstetric specialists each year. If employed by the Health Department this would be a part of her duties; if in private practice she should be indemnified for the time spent at the course.

The municipal midwife would be employed at a regular salary, her hours would be regulated, her holidays paid for and guaranteed and a pension would accrue to her at the close of her service. She would be able to call for a substitute or assistant in illness or in difficulty. She would work, not under a general practitioner, who might know very little of midwifery, but under a specialist obstetrician who would command her confidence.

As a public servant she would always be supplied with a telephone and the use of a motor for emergency calls and longer journeys, as in Sweden and in some cases here.

She would be supplied with the most up-to-date equipment of her profession and kept abreast with modern obstetric developments.

The midwife in private practice might remain for a time, but the competent nurse would in most cases prefer the assured position of the municipal servant.

## THE HOME HELP

This essential aid should be entitled to a free training, like the midwife; her training is, in fact, almost free in

## NATIONAL MATERNITY SERVICE 131

Sweden, as it should be here in this wealthier country. Still more important, she is entitled to receive regular employment from the Maternity Service, at a fair wage, with regular holidays and a pension at the close of her service. Like the midwife and the doctor, she would be subject to medical examination in the interests of the patients.

### A MATERNITY BOUNTY

A Bounty of £10 per birth would not be greater in actual present values than was the Australian Maternity Allowance of £5 when first established. Mrs. Grundy, even when she has graduated in medicine, is apt to complain that such monies are sometimes diverted to improper purposes, but incorrigible gamblers and drinkers are a comparatively small class; their existence should not be permitted to deprive the great masses of thrifty, self-abnegating mothers of a needed boon. Therefore let there be: A CASH MATERNITY BOUNTY OF £10, payable either on the notification of the birth to the Health Department or, if the mother desire it, in three previous instalments:

- (a) £3 to enable the expectant mother to provide herself with clothing or other comforts required by her condition, payable on the notification of her pregnancy;
- (b) £3 at seven months' pregnancy, to provide clothing, etc. for the infant;
- (c) £4 payable in the ninth month for the provision of nourishments, and comforts for the confinement. Should the child be premature, any outstanding payment would be made on notification of the birth.

## MATERNITY INDEMNITY FOR WAGE-EARNING MOTHERS

The mother has hitherto asked far too little from the community, in view of her great service and her great need. As mother and wage-earner she has patiently shouldered a double burden, and has been expected to bear it unaided, as the willing horse is expected to run.

A National Maternity indemnity should guarantee to her:

- (a) Weekly payments equivalent to her wage when employed, for five months before the birth of a child, or at an earlier stage on presenting a doctor's certificate that she is unfit to work on account of pregnancy.
- (b) Similar payments for twelve months after the birth of the child, if the mother remain away from work during that period.
- (c) Similar payments in case of an abortion or still-birth until the patient is restored to health.

No contract to be broken, or dismissal to be permitted, on account of failure to work during pregnancy, or for one year after the birth of a child.

No woman to be employed as a wage-worker within six weeks before or six weeks after the birth of a child. This proviso would be worse than useless, and indeed cruelly injurious, unless the mother were indemnified by payments equal to her earnings.

The proposal that maternity indemnity should extend from the time the child quickens until breast-feeding is over and the child is established in spoon-feeding and is taking a proportion of solid food has been criticised as too long. Yet the continuous strain of disciplined labour for wages, whether sedentary or otherwise, in which the same occupation, and frequently the same

process and posture are maintained for a number of hours, is unsuitable for a woman in advanced pregnancy, and does not conduce to the healthy development of the fœtus. "Do nothing long" is a good motto for the pregnant woman; she needs plenty of fresh air, plenty of gentle exercise, abundant rest and sleep.

The nursing mother has similar needs. In any event she will have upwards of nine months of short nights, and at the best many broken nights, even should she adopt the modern programme of five feeds in the twenty-four hours, and her baby be healthy and well managed. At the very best her system cannot follow nine months' pregnancy by nine months' lactation without strain. The idea that she can have the same reserves of energy to draw upon as a person not subjected to this strain is absurd. If she is to be mentally and physically a completely efficient mother, and is to recover her full health and vigour at the end of the nursing period, she must not be expected to bear the load of work and responsibility of the ordinary wage-worker in addition to the burden of motherhood.

#### MOTHERS' ALLOWANCES

As to the children: undoubtedly they would benefit if provision were made to exempt from wage-earning all mothers of children under five years desirous of applying for this relief. Even thereafter, unless a housekeeper or some friend or relative is an efficient substitute, there cannot be adequate comfort or care for the children where the mother is earning a living outside the home, or even if she is taking in home-work to provide a substantial share of the family income.

#### DAY NURSERIES AND CO-OPERATIVE HOUSEKEEPING

It will be objected that all women do not desire to be housekeepers and domestic workers and that many

mothers prefer to continue the trade or profession they practised before marriage. For such women the solution is co-operative housekeeping and day nurseries and nursery schools for the children. These should be established in all districts. The latter are needed by mothers who do their own housework as well as by wage-earners. All children benefit by attendance at a good nursery school.

#### NECESSITOUS CASES

The existence of the so-called "necessitous case" is a blot on the social order. Yet since crude poverty still remains with us, its ravages must be mitigated.

Food and milk, free or at cost price, for nursing and expectant mothers and infants supplied by some Local Authorities under the Maternity and Child Welfare Act, 1918, since they are found to be necessary, should be everywhere available. The doctor should in all cases be able to order invalid foods, as freely as medicines, for patients requiring them.



CHAPTER THIRTEEN  
SOME SCHEMES FOR AN IMPROVED  
MATERNITY SERVICE

THE sad persistence of the high maternal death-rate has aroused numerous bodies and individuals to propound suggestions for improving the service available to maternity.

THE BRITISH MEDICAL ASSOCIATION SCHEME

The British Medical Association proposes that to provide an improved service for maternity the present National Health Insurance contributions should be increased by 6*d.* per week, the employer, the worker and the Government each finding twopence. Non-insured persons of similar economic status to the insured would be invited to contribute the whole 6*d.* a week to secure the maternity benefit, or to pay, by instalments during the pregnancy, the whole or part of the cost according to the assessment of the Local Authority after consideration of the circumstances according to the old inquisitional methods.

With the money thus raised it is proposed to provide:

- (a) Care during pregnancy, labour and the puerperium by a registered midwife.
- (b) One ante-natal examination by a registered medical practitioner between the 32nd and 36th week of pregnancy and one post-natal consultation.
- (c) Such medical and hospital attention as may be required for abnormal cases.
- (d) Sterilised obstetric dressings.

It is proposed that each expectant mother should engage a doctor as well as a midwife early in the preg-

nancy, but that the doctor should in most cases neither be present at the birth nor visit during the puerperium. He would merely examine the woman at his own convenience on some date between the 32nd and 36th week of her pregnancy, either in his surgery, her home or a clinic, the midwife being present if possible. Some twenty-eight days after the confinement he would have a consultation with the patient, and if he thinks necessary would examine her. This, in practice, would mean that the woman would only be examined if her own complaints or the midwife's report had led the doctor to anticipate something wrong. Such a solution is by no means satisfactory; many a disability would be passed over to cause trouble later on, especially given the reluctance of women to complain, and their habit of letting morbid conditions drift till they become acute.

Nothing is said in this scheme of a medical examination for the new born infant—indeed a grievous omission. Twenty-eight days after the birth is in any case excessively late for this, in view of the high infant death-rate in the first week of life and the high rate also of ophthalmia neonatorum, which must mainly be ascribed to neglect of proper prophylactic precautions at the birth. In this connection the observation of the Glasgow Medical Officer of Health that a large proportion of these cases are notified by midwives and nurses calls for investigation.<sup>1</sup>

<sup>1</sup> REPORT M.O.H. GLASGOW, 1928.

Births Attended by doctors	6,858
"          "    by midwives	10,261

OPHTHALMIA NEONATORUM.

	Cases.	Rates per 1,000 births.
Notified by doctors . . . . .	40	6.0
Institutions . . . . .	73	20.6
Inst. Nurses . . . . .	145	40.8
Midwives, etc. . . . .	434	43.7

It is proposed to pay the doctor 10s. for the ante-natal examination and 5s. for each subsequent ante-natal attendance he may find necessary, or alternately a capitation fee of 11s. 6d. for the ante-natal work. A further 5s. will be paid for the post-natal consultation. If a second practitioner should be required to give an anæsthetic, a fee of one guinea would be paid to him. "It is estimated that not more than one-half of 1 per cent. of the total births taking place at the patient's own home would require this service."

As a result of his ante-natal examination the doctor would decide whether the patient should be regarded as a "normal" case to be left to the midwife; or whether, owing to abnormality, the doctor should attend the confinement, in which case he, or she, would be paid for that service on the scale at present paid by Local Authorities where medical aid is sought for necessitous cases; or whether the patient should be sent to hospital.

It is proposed greatly to extend the duties of the midwife, expecting her to record the previous history of the patient, and inquire as to her home conditions, advising on the arrangements for the confinement and on her general health. She would examine the patient on engagement, inspecting her teeth, ears, nose and throat, as well as the special conditions of pregnancy, and make a much more thorough inspection than is now usually made by either doctor or midwife. She would re-examine the patient at the 24th and 28th weeks, taking measurements, testing the urine, and so on, and thereafter would examine every fortnight until the 36th week, and thence forward weekly till the confinement, keeping records of every visit on a prescribed form. She would attend the patient in labour and visit her for not less than fourteen days thereafter, instead of ten as at present. On account of these extended services it is proposed to pay the midwife £2 10s. per case. It is

assumed that she could attend 110 cases per annum, though it is obviously impossible for a midwife to make the numerous ante-natal visits insisted upon, as well as attending an average of nearly three labours a week and nursing the patients through the confinement. It must be stated emphatically that no woman or man could do this work adequately.

The authors of the scheme observe that "a large proportion of midwives cannot be entrusted with the responsibilities described above." Nevertheless, no suggestion is advanced for reinforcing their services. On the contrary, it is urged that to counterbalance the cost of the scheme, the present ante-natal clinics shall be abolished, and "a large proportion of the cost of Mother and Child Welfare Centres" saved. Thus the expectant mother who to-day may attend a clinic throughout her pregnancy, and may thus be under the weekly observation of a qualified medical practitioner specialising in that work, would be examined but once by a panel doctor and for the rest would be left to the midwife. Albuminuria is but one of many serious conditions which might develop after the doctor's examination.<sup>1</sup> At present medical practitioners attend approximately 40% of confinements in England and Wales, and usually those where the mother's health is not good. The existence of an insurance providing a midwife, and not a medical practitioner, would tend to discourage insured women from engaging a doctor for whose services they would have to pay outside the insurance.

On the one hand, what might tend to be a false sense of security would be created by the doctor's decision

<sup>1</sup> "The majority of patients do not develop their first albuminuria until the last four weeks, and further albumin may appear almost immediately before serious danger threatens. Nearly all eclamptics we see in London have had their urine examined once at least many weeks before the disease began, but not again."—Aleck W. Bourne, M.B., B.Ch., F.R.C.S., Obstetric Surgeon St. Mary's and Queen Charlotte's Hospitals.

that the confinement would be normal, whilst the midwife might be more than at present reluctant to summon the practitioner who had given this verdict. On the other hand, the mother who had been informed that the doctor must be present because her case would not be normal might suffer undue alarm, knowing this to be an unusual precaution; a consideration of special importance during pregnancy, when women are often preyed upon by nervous anxiety.

The scheme would leave the midwife with her present responsibility of deciding whether and when the doctor should be called. Both pre-natally and during the confinement, she would be left, as now, to detect abnormalities, which, with her inferior training and education, might well escape her observation. Should abnormality develop there would still be the old risk to both mother and infant of delay in the doctor's arrival. Moreover, the scheme expressly debar the midwife from sending a case into hospital, or calling an obstetric specialist, compelling her to leave this decision to the general practitioner. Thus the critical emergency requiring immediate special treatment would suffer a dual delay.

The authors of the scheme discourage hospital treatment for "normal" cases, declaring that already more hospital beds for maternity exist than are actually required. In London, for instance, there are 427 beds, and the British Medical Association declared that "the number required in London, at most, is 300." "The normal case," it is asserted, "can safely be treated at home." The great question from the mother's standpoint is, can the normal maternity case be comfortably conducted in the average home? Can the mother secure the complete repose she needs during her confinement?

Whilst some normal cases would be allowed in the hospital, in order to provide material for training the doctors and midwives, the scheme would leave the

patients to pay the difference between the charge of the hospital and the fee ordinarily paid to the midwife by the National Insurance.

I cannot escape the conclusion that this scheme of the British Medical Association, though not without merit, would benefit the medical profession considerably more than the mothers whose health it purports to safeguard. Undoubtedly even with one ante-natal examination many abnormalities at present ignored will be discovered and the sufferer referred to a hospital for treatment, yet many equally serious conditions will go undetected until the hour of crisis.

#### THE MEDICAL WOMEN'S FEDERATION SCHEME

This scheme follows in the main the same lines as that of the British Medical Association, though a somewhat more ample service is proposed. The patient in this case would be twice examined by a medical practitioner during pregnancy (instead of once under the B.M.A. scheme) and once post-natally, the doctor being paid £1 10s. per case for these services.

It is regrettable to find that the medical women, from whom a more special concern for maternity and infancy might have been expected, parrot-like follow the men in relegating the difficult work of the confinement and puerperium wholly to the midwife. They make the proviso, forgotten by the portentous B.M.A., that the infant also should be medically examined; yet not, as emphatically should be the case, immediately after birth, but about the fourteenth day, or before the end of the fourth week. In upwards of 20,000 cases the infant will be dead before that time!

The women doctors do not echo the men in urging the abolition of the ante-natal clinics which have provided too valuable a field for women practitioners to be lightly discarded. They refrain from reference to the clinics. They are harsher than the B.M.A. in their pro-

posal that women who elect to go into hospital when the doctor has decided their case will be normal, should not get even the relief from insurance funds suggested by the B.M.A., but should pay the whole of the usual fees. Homes being what they are to-day, the medical women should have shown more tenderness towards the interests of their poorer sisters. They also declare that "wives of unemployed (*a*) gone out of insurance, or (*b*) in receipt of relief," though they may have the services of doctor and midwife, should get no cash benefit.

As to the midwife, the medical women would pay her £3 per case. They refrain from elaborating her antenatal duties as the B.M.A. has done, but suggest two visits per day for the first seven days of the puerperium, and one visit per day for the subsequent seven. They add ten cases per annum to the limit suggested for her by the B.M.A., egregiously proposing that she should deal with 120 cases per annum. In scattered districts they propose to lighten her labours by giving her the use of a small car, and by making the pregnant mothers, for whom no car would be provided, tramp to the cottage hospital in order that she may examine them. Obviously it is in the scattered rural districts that pregnant mothers most require that those whose province is to serve them shall visit them at home.

#### THE MIDWIVES' JOINT COMMITTEE

The various organisations representing midwives have formed a joint committee, which is urging that the following proposals permissive under the Maternity and Infant Welfare Act be made obligatory:

- (*a*) Subsidies to midwives in rural areas.
- (*b*) Provision of sterilised maternity outfits to mothers free or at cost price. (This would relieve the

## SAVE THE MOTHERS

- midwife of the cost of wool, etc. at present falling on her.)
- (c) Payment of part or whole fee of midwife, by the local authority, when the patient is necessitous.
  - (d) Provision of post-certificate training for midwives.

Additional powers for Local Authorities to provide:

- (a) Compensation for midwife if case sent to an institution.
- (b) Old age pensions for midwives.
- (c) Sickness and emergency relief for midwives.
- (d) Aid towards transport and telephone service in rural areas. Opposition to legislation transferring control of midwives from the Central Midwives Board, which includes representatives of the Government, the midwives, the medical profession and the Local Authorities, to a Government Department.

Inspection by the Central Midwives Board of all training schools, teachers and systems of teaching for midwives.

LABOUR PARTY AND STANDING JOINT COMMITTEE OF  
WOMEN'S INDUSTRIAL ORGANISATIONS SCHEME

The Joint Committee of the Women's Organisation attached to the Trade Union, Labour and Co-operative movements has produced a scheme for maternal welfare which has since been adopted by the Labour Party and includes the following proposals:

The permissive provisions of the Maternity and Child Welfare Act, 1918, to be made compulsory for all Local Authorities. Sufficient ante-natal clinics to enable all pregnant women to seek advice.

The extension of medical benefit to the wives of all insured workers.



## IMPROVED MATERNITY SERVICE 143

(In France medical benefit extends to the wife or husband and the children of all insured workers.)

For insured women workers and the wives of insured workers, free medical and nursing attendance in pregnancy and childbirth. This would include: "a considered medical opinion early in pregnancy," a midwife for "normal" labour and a doctor for abnormal labour.

(I should insist on the presence of a doctor in all cases.)

The Local Authority to guarantee the midwife "a fair income."

(Some Local Authorities already make grants to raise the earnings of midwives to a fixed standard. This plan is by no means so good as the establishment of a municipal service of midwives to meet all requirements.)

Sterilised maternity outfits, supplied cost free by the Local Authority, where they are not themselves able to provide them.

(I should say free in all cases.)

A home help trained and employed at a standing wage by the Local Authority, the patient paying for this service on a graduated income scale.

(This demand should be for a home help, without charge, as part of a free maternity service.)

Food for mothers in need of it free of charge or at cost price.

The raising of the income limit for National Health Insurance to £350.

The advantages of these maternity insurance proposals to be extended by the Local Authorities assisted by national grants to women not covered by the Health Insurance Acts.

(A comprehensive non-contributory scheme covering all mothers would be infinitely preferable.)

Sufficient maternity beds for all women "whose confinements are likely to be difficult, or whose home circumstances make confinement at home unsuitable or

dangerous;" such provision to be free, where necessary, with a rising scale of charges based on income.

Surely the demand might be for maternity beds for all women desiring them as part of a free maternity service. Incidentally the shortage of cases for students to watch would thus be met.

For women wage-earners a cash maternity benefit of at least £1 a week for twelve weeks, in addition to the present maternity benefit paid on the husband's insurance.

An inquiry into all maternal deaths.

#### SCHEME OF DEPARTMENTAL COMMITTEE ON MATERNAL MORTALITY

The Departmental Committee recommends:

Improved training of medical students, with six months hospital practice including two months residence, delivery of 30 patients and eight attendances at an infant welfare centre—little enough!

For the mother: three ante-natal and one post-natal examination by a medical practitioner, attendance in normal labour by a midwife, the doctor being present only in case of abnormality, consultant and hospital services being available on the doctor's order.

The Committee's insistence upon the need for laboratory and bacteriological services appears somewhat artificial, in view of its declaration that "there is practically no disadvantage" in permitting a district nurse to attend both lying-in mothers and people suffering from disease.

CHAPTER FOURTEEN  
THE CARE OF MATERNITY IN  
SOME OTHER COUNTRIES

1. Holland.—2. Sweden.—3. Denmark.—4. Norway.—  
5. France.—6. Germany.—7. Soviet Russia.—8. Latvia.  
—9. Poland.—10. The Irish Free State.—11. Australia.  
—12. New Zealand.—13. Canada.—14. Southern Rho-  
desia.—15. The United States.

I. HOLLAND

Holland possesses the finest maternity service in the world and is amongst the countries enjoying the lowest maternal mortality.

The Dutch medical student devotes more time to midwifery and women's diseases and has better academic and clinical opportunities than any other medical student in the world. The midwife has a better and longer training.

Professor Van Rooy of the Vrouwenkliniek, of the Amsterdam University, sends me the following account of the work there:

THE SERVICE OF THE UNIVERSITY COLLEGE  
MATERNITY HOSPITAL, AMSTERDAM, AND THE  
AMBULATION SERVICES ATTACHED THERETO.

Director: Prof. Dr. Van Rooy.

The Clinic has 208 beds, of which 100 are devoted to obstetrical and 108 to gynaecological patients.

The majority of the patients brought to the Clinic belong to the poor population of Amsterdam. They are treated gratuitously, and the Professor of

Obstetrics and Gynæcology of the Amsterdam University is responsible for their treatment. He is assisted by:

- 5 resident assistants;
- 1 chief assistant, entitled "Chef de Clinique";
- 1 outdoor assistant, head of the Laboratory;
- 1 outdoor assistant, head of the Physical-therapeutic Service;
- 2 assistants for the X-rays service;
- 1 woman-assistant (not a medical woman) for help in the Laboratory and as secretary to the Professor.

There are about 2,000 deliveries a year, nearly half of which are artificial confinements. This latter number is so high because most of the abnormal and difficult obstetrical cases in the city of Amsterdam are sent to the Clinic.

In the Gynæcological ward some 1,100 important operations are yearly performed.

Obstetrical and Gynæcological instruction to students of the University is given regularly in the Clinic; the students working in groups of eight, in the Obstetrical as well as in the Gynæcological ward.

There is also an Ambulatory service for Gynæcological, and one for Obstetrical patients. Under this Gynæcological service every woman can be examined, if desired, and treated "*pro Deo*." If necessary these women are brought in the ward. All patients, including those who have been under treatment in the hospital, are cared for by the Ambulatory service for a period the length of which depends on the gravity of their disease.

To the Obstetrical Ambulatory service pregnant women of Amsterdam come for counsel and are seen about weekly, until the moment they must be brought into the Obstetrical ward. If at the weekly

consultation the pregnancy is found to be complicated by albuminuria, loss of blood or other abnormality, the woman is sent at once to the Obstetrical ward; otherwise she is admitted about two weeks before the end of the pregnancy. This Ambulatory service is in operation every day. The students participate in groups, and thus become well educated in the hygienic care of the pregnant woman.

Every woman who has been delivered in the Clinic, when leaving with her child is referred to an Ambulatory service for BABY-CARE, of which several are established by the Municipality in various districts of the town. Here the women can obtain during several months advice and instruction for the care of their child.

In the Clinic is also a ward for PREMATURE BABIES. Here the Professor is assisted by a physician who is a children's specialist of great experience, having been working in this direction for many years.

The Clinic has an extensive service for X-rays, diagnostics and therapeutics, with two specially appointed whole-time assistants. Special nosographies are used in both the Obstetrical and Gynæcological wards.

In the fourth year of the medical course, after the students have had a year's general clinical instruction, the head of the Obstetric Clinic, who is also Professor of Obstetrics and Gynæcology in the University, gives a systematic course of lectures and readings, and delivers seven lectures a week, each of one hour's duration, of which five are devoted to Obstetrics and two to Gynæcology. For the students of the last two years, clinical cases are frequently demonstrated and discussed in these lectures. Moreover, in the afternoon the

students receive practice in operative Obstetrics on the phantom (clay figure). The number of teaching hours for Obstetrics are equal to those for General Surgery.

Instruction in Obstetrics has been given at the Amsterdam University for nearly a century. Until the middle of last century this was given by the Professor of Surgery; after that by a special Professor for Obstetrics, and since the year 1890 by the Professor for Obstetrics and Gynæcology. Gradually the number of teaching hours has increased, and at present the instruction in Obstetrics and Gynæcology is on exactly the same scale as that in General Surgery and Internal Surgery.

Professor Van Rooy adds:

“First and foremost, as a general rule, pregnant women are received into this hospital some time before their confinement. To make this practicable, especially where no other member of the family can take the mother’s place, we have at our disposal an organisation (subsidised by the Municipal Board) called ‘Social Work.’ This society either sends a housekeeper at a small salary, which varies according to the income of the patient’s husband, or boards out the children in some home or institution at a small charge per head, not too high for the family’s financial resources.

“Secondly, the training of our midwives take three years. This is much more extensive than anywhere else in the world.

“The low mortality in Holland is probably due to the high standard of pre-natal care entertained by our doctors and midwives. Another reason might very well be the innate love of cleanliness existing in the Dutch nation as a whole.”

Midwives receive an excellent three years' training in midwifery schools at Amsterdam, Rotterdam and Heerlen. The first year's training is mainly theoretical; the second year theory is continued, and practical work is done in hospitals; the third year includes practical work in hospital and in the district and two months' attendance at a Mother and Infant Welfare centre.

Maternity nurses have six months' hospital and eighteen months' training on the district. They undertake no deliveries, but nurse some of the patients delivered by doctors and midwives.

Some Co-operative and other Insurance Societies provide maternity benefit, and some Municipalities supply doctors, midwives and medicines to lying-in mothers. The Amsterdam Municipality employs whole-time midwives, paying them 2,500 to 3,500 florins a year (from £200 to £275 per annum). They attend from 180 to 200 labours each, but do no nursing.

Maternity nurses, also employed by the Health Department, undertake the nursing of the patient and attend for nine days after the birth.<sup>1</sup> Contrast these arrangements with the British practice, under which the midwife, who is the sole nurse to her patients, sometimes undertakes 200 or more cases! The usual fee for a private midwife is 25 to 30 florins (about £2 to £2 10s.). Municipal midwives are supplied to women who cannot afford the fee, but if it is anticipated that the confinement may not be normal they are sent to hospital. Midwives must always call for medical aid in case of abnormalities.

Various organisations supply baby outfits and ante- and post-natal nourishment to the mother.

Clinics for pre-natal and post-natal care and day nurseries play their part in mitigating the excessive strain which too often bears upon the mother. The Dutch clinics have long made a feature of giving con-

<sup>1</sup> They are paid 1,800 to 2,400 florins per annum.

traceptive information, and in Holland such teaching is recognised by the Government. It is claimed that the rates both of abortion and of too frequent child-bearing have been reduced by this means.

## 2. SWEDEN

Sweden, with one of the lowest maternal death-rates, is generally regarded as excelled only by Holland in its maternity service.

Mothers are granted a fortnight's leave of absence before the birth, on presenting a certificate from the doctor or midwife. They may not be employed for six weeks after childbirth, unless they present a doctor's certificate stating that they may do so without injury to themselves or the child. They are entitled to intervals for feeding their infants while at work.

The State makes grants to the registered sick insurance societies to pay benefits to mothers absent from work owing to childbirth, and the Government is investigating proposals for a more complete method of maternity insurance. Thirteen per cent. of the population is insured against sickness in registered Societies, and in 1926 241,782 women (*i.e.* 84·8 per cent. of the women members of sick insurance societies) obtained maternity benefit of one krona (about 1s. 1½*d.*) a day for an average of 30·5 days per confinement. Benefit extends for at least two weeks, at most 40 days under the sick insurance societies. The State pays 60 öre for every day for which maternity benefit of at least 90 öre (a little more than 1s.) is paid by the Society. Any sick insurance society with 100 members may be registered and receive State grants for its members, irrespective of sex, age, nationality, trade, profession or income. Continuation Societies carry on sick benefit after the term fixed by the insurance societies has expired.

For midwifery the country is divided into 2,000 districts, and there is a Midwifery Board in every



county, with the County Medical Officer as Chairman. This Board regulates the number of midwives in each area, and fixes the fees to be paid for the services of the district midwife, who is supplied on a scale graduated to the income of the patient and free to the poorest. The midwife gets a fixed salary paid by the State, the County Council and the local Commune of at least 940 kronor (about £52 per annum), with an increment of 100 kr. a year. After ten years she gets a free lodging; at least one or two rooms and a kitchen, with a plot of land for her vegetables, and free fuel and light, or in lieu of these at least 250 kr. per annum. She has no working expenses; for a free telephone and the materials required for her work, wool, disinfectants, drugs, instruments and appliances, are supplied to her without charge. The midwife attends from forty-five to fifty confinements a year, which gives her time to nurse her patients much more adequately than is possible here. Midwives are all trained in two State institutions at Stockholm and Gothenburg. Trainees must be between twenty-one and thirty years. The training course is entirely gratuitous. It includes twenty-three months of theoretical and clinical instruction spread over two years. There is a month's probation and an examination at the end of each year's training. Every ten years the midwife must take a refresher course of two weeks, which is mainly paid for by the locality. Reserve midwives are kept in each county to relieve the district midwives during illness or holidays. They are entitled to a fortnight's holiday annually. Both State and private midwives are under the supervision of the State obstetrician of their district, and must keep records and charts for each patient. They must give ante-natal care and advice, and call the doctor in case of abnormality, or if the patient or her family desire it. They may only use the forceps in emergency if the doctor cannot be procured.

In 1927 there were 1,825 county midwives, 326 employed by the village councils, 83 employed by hospitals, and 582 in private practice. Thus the great majority of midwives were employed by public bodies.

Home helps take an eighteen months' course at the institute at Upsala, including cooking, housework, mending, children's care, the laws and regulations which should be known to all citizens, general hygiene and six months' practice in sick nursing. The training course is entirely free, but 65 kr. per month (about 71s.) is charged for food and laundry. The State grants 15 to 25 kr. to assist poor students in paying for their course. When trained the home helps join the home nursing corps; their mission is to devote themselves to the poor, and many of them are women of great self-abnegation and much beloved. They go for about fourteen days to a family where the mother is ill or in hospital. They get 66s. per month and a food allowance, with free lodging, fuel, light and laundry.

Medical students are well trained in midwifery and there are many obstetric specialists.

Maternity hospitals are growing in popularity, and are insufficient to meet the demand. In 1900 there were seven maternity institutions with 216 beds, and 5,546 women were confined there. In 1927 there were 26 institutions, with 916 beds and 24,473 confinements. In the State hospitals the charge is about 2s. 6d. per day, including food, and all expenses are covered for about 33s., the patient receiving ante-natal examinations and all treatment required till the end of the puerperium whatever complications may arise. Those who choose to be second-class patients pay 6 kr. daily and share a room with one other patient. First-class patients have a room of their own and pay 10 kr.

The Swedish Red Cross, which receives financial support from the State, and is subject to Government control, co-operates with the State Medical Officers of

Health. Its social activities include the loan of baby clothes and nursing requirements for confinements. It maintains small lying-in homes near the houses of the district midwives, and in 1927 was providing 230 beds in 50 lying-in homes. It supplies home helps when the mother is ill from maternity or other causes.

In 1928 infant welfare organisations had established forty Milk Dispensaries, of which six were in Stockholm and Gothenburg. The cost was provided in part by donations and subscriptions, in part by the Local Authorities. The work of these institutions includes mother and infant consultations and the dispensing of milk and milk mixtures to mothers and babies, and the provision of homes which enable poor mothers who would otherwise have to go out to work to remain with their children during the period of lactation. Infants' homes are established where wage-earning mothers, married or unmarried, may live with their children. The first crèche for infants and children under school age was established in Stockholm in 1854, the first kindergarten for children under school age in 1896. The latter are increasing in number and are subsidised by the Local Authorities, and there is a growing demand for trained teachers. Children's workshops were started in 1887. These aim at occupying school-children in their free time, especially when there is no one to look after them at home. They must be a great boon to wage-earning mothers and mothers of large families, as well as to the children themselves. The children learn brush-making, basket-weaving, wood-carving, carpentry, metal-work, tailoring, weaving, sewing, shoe-repairing, cooking and domestic work, etc. They are given one or two meals and receive payment if their work is sold. These institutions are supported by donations and grants from the Local Authorities, and by the sale of the children's work. Infants' hotels, where children may stay when the mother is ill, and vacation

colonies in the country for town children are similarly maintained.

Since 1917 children born out of wedlock occupy towards their mother the same legal position as a child in wedlock occupies towards both parents. The mother has the custody of the child and is its guardian; but the father must contribute to its support so that it may be brought up on a scale compatible with the position of its parents. If their positions are dissimilar, a suitable means must be found in fixing the maintenance. Every child born out of wedlock has a person appointed by the Child Welfare Board to safeguard its rights until the age of eighteen. This Trustee will assist the mother with advice and information, and may sue on the child's behalf in respect of paternity, maintenance and guardianship, but the mother remains the legal guardian. An agreement for maintenance approved by this person is legally binding. If the child was born while the parents were engaged the child may bear its father's name and inherit after him. Anyone who cohabited with the mother when the child was conceived is regarded as the father and must contribute to the support of the child and that of its mother during six weeks before and six weeks after the confinement; or, if she is ill, up to four months before and nine months after the confinement. If more than one man has cohabited with the mother, each must share the cost. The mother may go to the Child Welfare Board three months before the child is born and have all such matters arranged for her, and it is the duty of the Board to insure that if support from the father or other sources is not forthcoming, it shall be provided from public funds. The local Child Welfare Board is appointed by the local Council, and must include a teacher or an inspector of schools, a clergyman, a physician employed by the county or the locality, and two persons known and respected in the district.

## 3. DENMARK

Danish midwives must train for two years. Pupil midwives at the Rigs Hospital, where thirty pupils are trained annually, must be not less than twenty nor more than thirty years of age. They live at the hospital, and take part in the work there under direction, as well as following the usual curriculum. A month after entering the school they must pass an examination in reading, spelling and general knowledge. The fee for the whole training is 50 kr., plus 1.25 kr. per day for board and lodging, and 10 kr. per month for laundry; but after a time probationers may apply for a scholarship.

Post-registration courses for midwives are held annually and participation is open to all midwives.

Some of the trained midwives go into private practice, others become district midwives, of which there are about seven hundred in Denmark. They are then paid a subsidy of 700 kroner a year, rising to 1,000 kroner, which is provided by the State and the Municipality, and also receive a free house and telephone. They keep any fees they make in addition and retire on a pension at sixty-five years of age.

The majority of mothers are attended by midwives, who must call a doctor in case of need. Midwives are paid by the patient or by the community, according to the means of the patient; doctors, by the patient or by the Health Insurance. Insurance is voluntary, but two-thirds of the population are insured.

Copenhagen has the lowest maternal mortality of any European capital (5.9 per 10,000 births).

The genius of the Danes has built up a society conspicuous for its sane avoidance of the extremes of wealth and poverty, its mutuality and co-operation, and its high level of general culture and education.

## 4. NORWAY

By Betzy Kjelsberg,<sup>1</sup> Secretary of the Norwegian Women's Council, who was the first woman factory inspector appointed in Norway.

1. *Laws which protect mother and child.*

(a) Law concerning the protection of workmen, 18th September, 1915, with supplemental laws.

By these a woman who has given birth to a child *shall* not work during the first six weeks after the birth, and she *can* be free during the four weeks immediately preceding confinement. She is entitled to resume her employment after six weeks, and also to go home during working hours to suckle her child.

(b) Law concerning sickness insurance of August 6, 1915, with supplemental laws.

These give the mother the right to receive relief during two weeks before the birth and six weeks after, and in addition a free midwife. If a woman is placed in a lying-in institution, members of the family at home are entitled to a percentage of the above in accordance with the amount of support.

(c) Law concerning the support of children of April 10, 1915, with supplemental laws.

These give the mother a right to support for six weeks before the birth and six months after.

2. *Municipal laws.*

Pensions for mothers have been introduced in two municipalities—Oslo, Sarpsborg and Elverum.

3. *Training of doctors and midwives.*

Medical students have one year's training in obstetrics at the Women's Clinics in Oslo and Bergen. Midwives are trained at the same institutions. The period is one year.

<sup>1</sup> Kindly supplied through the Secretary of the British Legation in Norway.

4. *Other measures taken to protect mothers and infants.*

Some Local Authorities have established lying-in homes, and the same is the case with certain private associations. In addition, there are mothers' homes where mothers can stay for a period not exceeding one year, and where the child is attended to whilst his or her mother is out at work. Further, there are infant stations where children and mothers are medically examined; milk stations where mothers are supplied with milk, cod-liver oil, oatmeal, etc., free of charge; public nurseries in which mothers can place their children whilst they are at work, and from which they are fetched in the evening, and infants' homes where children remain from birth until they are three years of age. In addition, there are two mothers' hygiene offices in Norway.

The above is a general survey of the laws and measures for the protection of mothers and infants.

The latest official statistics (1927) state that 51·1 children per 1,000 born living died before the age of one year.<sup>1</sup>

## 5. FRANCE

Infant welfare work has been taken up with great enthusiasm in France, and an abundance of literature is published on this question by the Government and by private organisations. Maternity has long been regarded with greater public sympathy and tenderness in France than was the case here, at least until recently. The French Government is anxious to increase the population, and systematic efforts have been made over a considerable period to encourage large families, and to lessen the economic burden which rests upon the mother.

<sup>1</sup> Maternal mortality in Norway in 1921-5 from all causes was 2·65 per 1,000 births, from sepsis 0·75.

The need of the pregnant woman finds a ready response in the popular heart. Many institutions receive expectant mothers at seven months' pregnancy or earlier. The Municipalities of Paris, Lyons and other towns grant subsidies to them at seven months. Various charities provide two meals a day at free restaurants for women five months pregnant, as well as milk for nursing mothers, layettes and sterilised maternity outfits. L'Œuvre de l'Allaitement Maternel, founded in 1876 by Mme. Bequet, receives, freely and without inquiry, women seven months pregnant, married or unmarried, and of any or no religion.

The Government of the Department of the Seine gives indigent mothers assistance in cash and kind for each child up to three years, making allowances for children kept with their mothers, and also for those sent out to nurse. There are municipal and private convalescent homes, where mothers stay from two weeks to two months, and secondary convalescent homes, where they may stay till the child is weaned. The infant welfare clinics give free advice and free milk daily, prepared according to the doctor's instructions, for the twenty-four hours. Mothers receive 25 francs for regular attendance at the clinics for one year and one franc for each visit, and 50 francs if the infant is still breast-fed at one year.

There has been a steady development in the State provision for sickness and invalidity and for maternity. By an Act passed in 1893 all indigent French citizens are entitled to free medical attention at home or in hospital, and this provision applies also to maternity. Under an Act of 1st July, 1901, a wage-earner's insurance was set up, giving (1) a birth allowance of 250 francs for the first-born child, and 150 francs for subsequent children, half of which is payable a month before, and half a month after the birth of the child; (2) a nursing allowance of 50 francs a month for six months



in respect of breast-fed infants, and 70 francs a month in the case of twins; (3) monthly allowances for all the children as follows: 10 francs for one child, 40 francs for two, 90 francs for three, 170 francs for four, and 80 francs per child for all subsequent children, the allowances to continue up to fourteen years. These allowances to be paid to the mother, or person in charge of the children. The persons whose children were made eligible for these allowances were employees of firms affiliated to the insurance scheme, including fathers of families, widowed mothers, deserted wives, divorced mothers (or fathers having charge of the children), fathers of illegitimate children they had recognised, unmarried mothers of children not recognised by their fathers, persons in charge of orphans or adopted children. The allowances are payable to the children in respect of the father or mother, whichever is the insured employee. If the insured employee is ill, or incapacitated, or dies, the allowances are continued as before.

An Act of 22nd June, 1923, gives families with four or more children, born in or out of wedlock, who are under thirteen years, or are apprentices and students under sixteen years, 360 francs a year each, for the fourth and subsequent children. Widows and deserted wives get the same allowance for the second and subsequent children, widowers for the third and subsequent children. Families may draw this national bonus of encouragement for large families, as well as the wage-earners' insurance, established in 1901. Under Acts passed 14th July, 1913, and 30th April, 1926, these benefits were extended to the children of foreigners living in France, whose Governments have treaties of reciprocity with France in such matters.

By Acts of 17th June, 1913, 2nd December, 1917, 24th October, 1919, and decrees of 17th and 26th December, 1913, and provisions of the Code of Labour,

every French mother, whether a wage-earner or not, whose means are insufficient to maintain her, may obtain through the local Mayor a daily allowance varying in different districts from half a franc to a franc and a half, during the four weeks preceding and the four weeks following the birth. If breast-feeding her infant she gets an additional half franc (in Paris two-thirds of a franc). She is also entitled to 15 francs a month for twelve months if her child is breast-fed.

A decree of 30th April, 1920, and an Act of 30th April, 1921, accorded a subsidy to Local Authorities which institute a birth allowance for all families irrespective of their income. In May 1928, 65 departments had adopted the scheme for all their communes, 12 departments had adopted it for some of their communes, only 13 had not adopted this provision in any part of their area. The allowance varied from 100 to 1,000 francs, usually half paid at the birth, half when the child is a year old.

The very extensive Social Insurance Law of 5th April, 1928, came into force in January 1930. Under this law insurance is obligatory for employees of either sex whose wages do not exceed 18,600 francs per annum, plus 2,000 francs for each dependent child, and minus 3,000 francs for childless people. This Social Insurance provides maternity, sick, old age and death benefit, pensions and widows' and orphans' maternity benefit. Mothers during pregnancy and six months afterwards get 80 per cent. of the cost of medical attention and 85 per cent. of the cost of medicines. The mother is free to choose her own doctor or midwife; but if these are outside the district, or the fee of the doctor she chooses is higher than that of the district, she must find the extra cost. For six weeks before and six weeks after the birth the mother is entitled to benefit equal to half her wages, on condition that she abstains from work. If her earnings are low, she may get 60 per cent. of her wages.

Mothers who feed their children at the breast are entitled to 100 francs a month for the first two months, 75 francs the third month, 50 francs a month from the fourth to the sixth month, 25 francs for the seventh to the ninth and 15 francs for the tenth to the twelfth, *i.e.* 545 francs for the twelve months. A mother unable to feed her child on account of illness may receive two-thirds of this allowance until her recovery.

In case of illness the insured worker is entitled to 50 per cent. of his or her salary up to six months, and thereafter to 40 per cent. or less. The insured worker and his or her spouse, married or unmarried, and their children are all entitled to 80 per cent. of the cost of doctor and 85 per cent. of that of medicines and hospital treatment up to six months.

Reductions are accorded in school fees, railway fares, rent and taxation for large families. A bronze medal is given to mothers of five living children, a silver medal to mothers of eight, and a silver-gilt medal to mothers of ten living children. State employees get family allowances (under an Act of 4th August, 1926), 604 francs 80 for the first child, 806 francs 20 for the second, 1,209 francs 60 for the third, 1,411 francs 20 for the fourth and each of the subsequent children.

The family allowances, so much debated in this country, are, in short, an accomplished fact in France. They may be a factor in lessening the excessive strain upon the mother who has the task of making the family income stretch to meet all needs.

A pregnant woman may leave her employment on presenting a medical certificate stating her condition. Her absence from work during twelve weeks before or after the birth does not justify breaking a contract for her services, and whoever attempts it is liable for damages to be applied for her benefit. An employer may not dismiss a woman suffering from illness or incapacity due to motherhood who is absent from twelve

to fifteen weeks. A woman may not be employed in industrial or commercial establishments within four weeks after her confinement. Gainfully employed mothers are entitled to half an hour's rest in the morning and afternoon for feeding their children, and are entitled to feed their children in the factory where they are employed.

French midwives must study twenty-two months before taking their diploma. They must pass an entrance examination or present a school certificate equal to it; also an interim examination at the close of the first year and a final examination and clinical test.

If married, they must present before entering the training school their marriage certificate and husband's authorisation for them to take the course, or the husband's death certificate, or a certificate of divorce or separation. Such subordination to the husband would no longer be tolerated here; French women would do well to look to their independence. They must also present a recent certificate of vaccination and of good conduct and a certificate from the police.

The Administration of Public Assistance pays the midwife 100 to 150 francs for the confinement. This is equivalent to one-third or one-fifth of a clerk's monthly stipend. Thus the pay of the midwife is relatively better than in this country.

Girls are employed in the mother and infant clinics whom it is hoped will train as midwives when they are old enough. Midwives, termed social assistants, are employed in rural areas to advise at the clinics, and give free attendance at the confinements; to obtain such posts they must study for two and a half years.

In spite of all that is done for maternity, Mlle. C. Mossé, sage femme en chef de la Maternité, at a conference of L'Association des Anciennes élèves de la Maternité de Paris in 1928 declared that 50,000 French women were still attended in childbirth by untrained women.

## 6. GERMANY

A brief review by the Director of the Clinic for Women for the Province of Brandenburg.<sup>1</sup>

"1. According to the Reichs Insurance Regulations, paragraphs 195*a* to 205*a*, a weekly grant, as well as a bounty for maternity, medical and midwifery aid, medicines and other necessaries, is afforded to women lying-in. If insurance contributions have not exceeded 300 days within the last two years, a weekly welfare grant is then afforded to distressed persons according to paragraph 12 of the Reichs Regulations, payable by district or State welfare associations, and amounting to at least the same as they would grant for weekly family relief. As a matter of fact, the city of Berlin pays maternity applicants the usual rate given by private insurance societies, which fluctuates between Mk. 1.20 and 1.50 per day for weekly grants, and 50 Pfennigs bounty for maternity. Weekly grants are afforded for a period of ten weeks at the most, but these may be prolonged up to twelve weeks. Bounty for maternity is given for a period of twelve weeks if mothers nurse their children.

"2. There are official midwifery courses for midwives only. Midwifery training for medical practitioners is a part of their medical studies.

"3. (a) Midwives are officially registered with the State District Officers before commencing the practice of their profession.

(b) The necessary qualifications for midwives are obtained on passing their State examination.

"4. Midwives who pay their own premiums can become members of the State old-age insurance scheme. Pensions are only paid to midwives employed in the public service.

"5. Application by the woman lying-in can be made

<sup>1</sup> Kindly supplied by the British Consul in Berlin.

for a home help; firstly, to the Health Insurance Centre, whereby a deduction of half the weekly grant per day is made; secondly, to the competent district courts, which are in touch with various home-help associations, and engage employees from there at a fixed rate. The cost of the home help must be refunded by the distressed person at a later date, unless application for the waiving of incurred costs be made by the Maternal Welfare Centre."

#### 7. SOVIET RUSSIA

Women are paid full wages for two months before and two months after the confinement, and the law is strictly enforced. Office workers are only paid for one month before and after confinement (the distinction seems to me very regrettable). A grant is also made for the child's outfit, and a feeding allowance for nine months. In 1927-28, 27,249,000 rubles were paid for maternal wages on account of childbirth, 22,711,000 rubles for infants' outfits, 46,149,000 rubles for feeding allowances. The total budget for workers' insurance amounted to 969,200,000 rubles, of which 96,109,000 rubles, or 10 per cent. of the total, was allocated to maternal and infant welfare.

Day nurseries are a prominent feature of Russian life, and both wage-earning mothers and peasant women working on their own land are urged to make use of them. As far as possible the day nurseries are under the direction of doctors and educationists and the children receive medical attention. In the whole of Soviet Russia, including the R.S.F.R.S., the Ukraine, Georgia and the other republics, there were in 1929, 1,433 factory nurseries attended by 54,819 children.

Summer nurseries are opened in the country for 100 days each year, to care for the children whilst the adults are at work in the fields. In 1921 there were only 46 such nurseries, all of them in the Ukraine; in 1929 there

were 8,948 throughout the Union of Soviet Republics. Each nursery can accommodate thirty children.

Widespread efforts have been made to reduce infant mortality. In Czarist Russia the infant death-rate long averaged from 25 to 28 per cent., rising in some areas to 40 and 50 per cent. It is still appallingly high, though the rate had fallen to 21 per cent. in 1927.

Welfare Centres for mothers provide free milk in necessitous cases, as well as advice and instruction by doctors and nurses, and are open for six hours daily. There were in 1929, 1,399 Welfare Centres in the towns, and 905 in the rural districts of the R.S.F.S.R., serving 70 per cent. of the infants under one year in the towns and 6 per cent. in the country.

Before the Revolution there were 7,543 hospital beds for maternity and 2,326 midwives. These were together capable of dealing with only 10 or 11 per cent. of the confinements. In 1928 there were 15,767 hospital beds for maternity, and 8,000 midwives; 21 per cent. of mothers now receive attention from doctors or midwives. Thus the proportion is still grievously small, especially in the country. In the towns 86.9 per cent. of births took place in hospital, whereas the percentage having skilled aid was only 12.8 in the country.

Midwives are well trained; it has been obligatory for them to take a three-years course in a special training institution. In the country they are frequently obliged to deal with the most complicated labours without medical aid; yet, to add to the roll of midwives as rapidly as possible, their training course has now been reduced by one year. The number of training institutes has been multiplied by four, and 4,000 midwives can now be qualified annually.

It is of great interest to note that the maternal mortality in hospitals is exceedingly low as compared with the total maternal mortality in this country, above all with the grievously high rate, especially from sepsis,

registered in too many English hospitals. In pre-revolution days the maternal mortality in Russian hospitals was 4 per 1,000 births; it was 2.6 per 1,000 births in 1927. Some racial factor perhaps in part contributes towards immunity, for in the United States the maternal mortality is low amongst Russian and also amongst Italian women, as compared with that amongst many other races. I am inclined to think that one factor in this diversity is that the Italian peasant woman, with traditions based on the home-grown food of the small holding, and the Jewish woman following old traditions of feeding, are able, even under town conditions, to select and prepare a better diet with the same financial resources than the women of more highly commercialised nations. The nourishment of the pregnant woman is obviously of great importance.

Ante-natal centres advise women on pregnancy, birth control and the avoidance of abortion. The number of such centres is still small; it has risen from 29 in 1922 to 683 in 1929. Treatment in maternity hospitals is free.

In Czarist Russia about 70,000 children were abandoned annually. They were taken to orphanages and reformatories, and from 70 to 90 per cent. of them are said to have died. It is estimated that 5,500 children are still abandoned each year. Homes are now established for "lonely mothers" with their children: 4,000 orphans and children whose parents cannot or do not support them are placed in private families each year.

As in Scandinavia, the unmarried mother and her child have not to meet the grievous social boycott often directed against them here. They have no legal disabilities, the father has the same responsibility towards all his children whether the union of the parents were registered or not, and the mother's claim to support from the father and his claim upon her are on the same footing whatever may be the character of their union.



Briefly put, sexual union is in effect marriage, whether registered or not, as regards responsibility for its results. Unions may be dissolved and new unions formed without difficulty, but the claim of the children upon their parents remains, and one or several old partners may claim support from the departed spouse for the maintenance of the children. As Alexandra Kollontay has urged the weakness of the position is that few men under existing economic conditions can support more than one family.

#### 8. LATVIA

Women wage-earners get from six to eight weeks' leave of absence for their confinement. If State employees they get eight weeks' leave of absence on full wages. State insurance provides eight weeks' maintenance for mother and child. If at the end of that time the mother has failed to recover 60 per cent. of her working capacity, maintenance is continued for an extended period. The State Insurance entails contributions of 40 per cent. from the employer and 60 per cent. from the worker, whilst the State pays the cost of administration and provides a free midwife. Destitute uninsured women are supplied with a free midwife or admitted to a maternity home.

State employees get increased pay for each child under fourteen years.

#### 9. POLAND

In Poland working mothers are entitled to six weeks' leave of absence before and six weeks after the birth, and during pregnancy to six days' holiday each month. No employer may break his agreement with a woman on account of such absences. Mothers are entitled to two half-hour periods daily for feeding their infants, which are counted as part of their working time.

Day nurseries are attached to the factories for children under fifteen months of age, staffed by one

trained nurse to every thirty infants and under care of a doctor. Each child must have a separate bed with proper bedding.

Insured women get medical benefit during and after delivery, a subsidy for eight weeks and a further allowance for twelve weeks. The wives of insured workers receive half the twelve weeks' allowance.

There are three State Schools for midwives and five others. The schools train new midwives and re-educate those who are practising. In 1928 there were 7,032 midwives, most of them working as district midwives and paid by the local authorities.

On August 14th, 1924, regulations were issued governing the duties of women who nurse other people's children. Such women must present a medical certificate proving themselves free of infectious or contagious disease. They must take the baby to the infant welfare centre at regular intervals.

#### 10. IRISH FREE STATE

Maternal mortality in Ireland (1926=4.89 per 1,000 births; 1927=4.51; 1928=4.93) is slightly higher than in England and Wales (1926=4.12 per 1,000 births; 1927=4.11; 1928=4.42).

The Irish Local Government Board may make grants to voluntary agencies and Local Authorities: to defray 50 per cent. of the cost of providing food for expectant and nursing mothers; midwives and doctors for necessitous cases; hospital treatment in case of need; to encourage the provision of lying-in homes for normal and abnormal cases; for "home helps"; boarding out of children during the confinement; day nurseries and ante-natal and mother and infant clinics, including wards where mothers and infants may be taken in together, in case of difficulty in breast-feeding.

The Carnegie Model Child Welfare Centre, equipped at a cost of £25,000, serves as a model for the rest of

Ireland. (Free midwifery and medical attention in childbirth is provided under the Medical Charities Act, or from other sources in necessitous cases.)

Dispensary midwives, employed under the Medical Charities System on terms of part-time service, receive salaries varying from £30 to £67 per annum. County Meath, for instance, pays £52 per annum, rising by annual increments of £2 to £67. County Cavan £35 per annum, rising by £1 per annum to £67. Subject to the discharge of her prescribed duties, the dispensary midwife is not debarred from engaging in private midwifery practice and may retain her fees. There is the germ here of a national midwifery service.

#### II. AUSTRALIA

The £5 Commonwealth maternity allowance established in 1912 is payable on the birth of a viable child; no extra payment is made in case of more than one child at a birth. All inhabitants of Australia and persons intending to settle there, except Asiatics and aboriginal natives of Australia, Papua or the Pacific Islands, were originally entitled to this grant; but an Act passed in 1926 struck out "Asiatics" and substituted the word "Aliens." This result of the war mentality was modified in 1927 so as to obviate the disqualification of British women married to aliens.

The maternity allowance applies throughout Australia, and other arrangements for maternity are in the main similar in all States, although separately made by each State Parliament. Midwives have twelve months' training, or, if already registered nurses, six months'. In South Australia they must be not less than twenty-five years of age on sitting for their final examination.

The Children's Welfare and Public Relief Board of South Australia consists of a chairman and eight other members, four of whom must be women. The children

under seven years of unmarried mothers are under the supervision of this Board. The home of such children is subject to entry and inspection at any time, unless the Board is assured that the child is properly cared for. The unmarried mother may claim £10 from the father of her child to pay for her confinement. (This goes to prove that the £5 maternity allowance is far from covering the expenses.) Mothers, whether married or unmarried, who are unable to provide for their children may apply to the Board for their maintenance, and if adjudged deserving, they may be granted up to 15s. weekly per child till the child is fourteen. In special circumstances the allowance may be increased and paid till sixteen years of age. The father or mother of any child, whether legitimate or illegitimate, who fails to provide proper maintenance for it is liable to a fine not exceeding £50, or six months' imprisonment. In the case of legitimate children step-parents and grandparents are liable to a fine of £10 or three months' imprisonment for failure to maintain the child, and the mother's husband is so liable in respect of an illegitimate child.

In Queensland infant welfare work commenced in 1917. In 1928-9, 31 per cent. of the infants (in some towns nearly 100 per cent.) were attending the mother and infant centres. To reach children in outlying districts motor-cars are now being provided and nurses are learning to drive. Infant mortality in 1928 had fallen to 45·5 per 1,000 births. Of the 900 infants who died in 1928, 572 succumbed from ante-natal causes. The maternal mortality is 5 per 1,000 births. Queensland has 70 maternity hospitals. The Maternity Act of 1922 gave power to establish State maternity hospitals, hospitals for women's diseases and schools of midwives and women's diseases, also ante-natal and baby clinics to be co-ordinated with the maternity hospitals.

## 12. NEW ZEALAND

New Zealand has the lowest general death-rate and the lowest infant mortality in the world (36.18 per 1,000 births in 1928). Yet maternal mortality in 1928 was 4.93 per 1,000 births, as compared with 4.42 in England and Wales.

In New Zealand more than half the infant death-rate is from pre-natal causes and occurs in the first week of life.

The question of maternal mortality is now receiving great consideration, largely under the stimulus of Sir Truby King, whose great work for infant welfare is of world-wide renown and influence. The Royal New Zealand Society for the Health of Women and Children, initiated by him in 1907, has been the leading force in infant welfare work. It has established a large number of Mother and Infant Welfare Centres and six Karitane Harris baby hospitals and mothercraft homes where Karitane babies' nurses are trained during one year and four months. Sixty Plunket nurses are trained annually at the Karitane Harris Hospital at Dunedin. These nurses are trained for service in the Maternity and Infant Welfare Centres and are qualified to advise on the health and well-being of mothers and infants. Only candidates who are on the New Zealand Register of trained nurses or midwives (preferably both) are accepted for training as Plunket nurses. Dr. Helen Deem set an example to the medical profession by qualifying as a Plunket nurse after she had taken her University degree, and as a preparation for special investigations in the field of maternal and infant welfare.

In New Zealand there is no exception to the rule that midwives must be qualified by training and examination. The handy-woman and old *bona-fide* midwife can no longer practise. An unqualified woman can only act under a medical practitioner, and only if he signs a

declaration that owing to the circumstances he is willing to accept her services as nurse. A candidate for training must be either a registered trained nurse or a registered maternity nurse, who has had twelve months' training and has practised as a maternity nurse for twelve months. Registered nurses must undergo six months' midwifery training to become a maternity nurse. The midwifery training is eight months for a registered nurse, four months for a registered nurse who is also a maternity nurse, and four months for a maternity nurse.

Maternity nurses can only assist at a confinement where a doctor takes responsibility for the case. Midwives and maternity nurses must not be less than twenty-two years of age on registration.

The rules governing the work of New Zealand midwives do not permit them to take so much responsibility as in this country. They must summon medical aid for all presentations other than an uncomplicated vertex; or if the placenta is not expelled and cannot be expressed in one hour after the birth of the child; and in the case of a lying-in woman "who after delivery does not make satisfactory progress." Midwives and maternity nurses are not permitted "to make use of any instrument to aid delivery, or to administer ergot, pituitrin, or other ecbolic drug, before or during labour," or chloroform, or other anæsthetic, except by the direction of a medical practitioner. To do any of these things in New Zealand is to be deemed guilty of a malpractice.

The Royal New Zealand Society for the Health of Women and Children provides gratuitous short courses of one month to registered midwives and maternity nurses in which lantern slides reveal to them the developments in and around the pelvis from conception to birth, and what may happen from sepsis, venereal disease, or birth injuries. Lantern slides reveal the same development in the case of the child. To these post-

graduate courses students are sent with bursaries by the hospital Boards.

The State Maternity Hospitals charge £3 for the confinement and fourteen days' treatment in hospital, with 3s. daily for ante-natal and waiting patients. Out-patients are charged £1 plus the travelling expenses of the nurse for the confinement and ten days' treatment. If the mother has died, 10s. a week is charged whilst the infant is in hospital.

*Widows' pensions* are payable in respect of all children under fifteen years, whose parents have inter-married or for legally adopted children, at the rate of 10s. weekly per child and 10s. extra, the total not to exceed £4 a week and the total income not to exceed £5 10s., or £2 10s. plus children's pensions, whichever is less. The mother must be adjudged sober and of good moral character and the magistrate must be satisfied that the pension will be used for the good of the child.

Though the law gives her no claim, the unmarried mother may get the allowance for her children if the magistrate deem her deserving and sufficiently needy.

*State Insurance*, after twelve months' contributions, provides £6 maternity benefit, but this is not paid if the income exceeds £300 a year.

After contributing for five years the insured person, if incapacitated, gets 7s. 6d. per week for each child under fourteen years. On the death of the contributor the same allowance is paid per child and 7s. 6d. a week to the widow as long as she has a child under fourteen years. At sixty years the contributor draws a pension varying from 10s. to 40s. weekly according to the weekly contributions he has paid. If he joined at sixteen years, contributions vary from 9d. to 3s. weekly; if he joined at twenty-six, 1s. to 4s.; at thirty, 1s. 9d. to 7s.; at forty, 3s. 6d. to 14s., and so on. Whilst the contributions are exceedingly high for small wage-earners, the benefits are substantial.

## 13. CANADA

Canada has a high maternal mortality. In the period 1923-7 it was 5.78 per 1,000 births. The scattered population and the isolated position of remote farms makes medical and nursing care a difficult and expensive problem. The province of Saskatchewan authorises Local Authorities to pay up to 5,000 dollars annually for a physician to attend to maternity cases. A few municipalities in Saskatchewan and Alberta employ doctors and midwives. In that province in 1922 no less than 33 per cent. of births were attended neither by a nurse nor physician. In other provinces the rate varied from 10 to 50 per cent.

Under the Saskatchewan Public Health Act of 1920 the Commissioner of Public Health may grant up to twenty-five dollars to needy expectant mothers for medical, hospital or nursing attention, clothing and other needs. Ten dollars is usually sent in advance to the mother to provide herself with necessaries, the remainder goes to the hospital or doctor in attendance.

In British Columbia expectant mothers may have leave of absence for six weeks before the birth, and may not be dismissed for such absence, or even if they remain away for a longer period. The penalty for dismissing a woman for absence on account of pregnancy is one thousand dollars. Mothers may not work at gainful employment for six weeks after the confinement.

Some municipal hospitals have been established in Saskatchewan and Alberta and some outpost hospitals by the Canadian Red Cross; many of these take maternity patients. Mother and infant ante- and post-natal clinics are established in many towns.

The Red Cross in Toronto and the Victorian Order of Nurses in Ottawa and Winnipeg provide a small number of visiting housekeepers for aid during the confinement.



Mothers' allowances for widows and destitute mothers are established in several provinces.

The Canadian Health Department is exceedingly zealous, and the section for mother and infant welfare, under Dr. Helen McMurchy, publishes much popular literature. A valuable inquiry into maternal mortality was carried out 1925-26.

A major cause of mortality is said to be that the mothers work too hard on the farm.

#### 14. SOUTHERN RHODESIA

Southern Rhodesia is in some respects in advance of European standards. The Government maintains a service, not of mere midwives, but of qualified medical practitioners, whose services are available for indigent women in childbirth. On an order from the doctor all the necessary drugs and dressings are gratuitously supplied from Government funds. Food and milk is supplied to necessitous nursing mothers and infants. These provisions apply both to native and European patients. Maternity hostels are subsidised by the municipal councils and Government grants of one pound for every pound received from fees, donations and other sources of income. The hostels must provide accommodation for non-paying patients certified as necessitous by the magistrate, or by the Local Government doctors who usually attend these patients whilst they are in hospital. Child Welfare Centres are managed by local committees and financed by the Government, the municipalities, and private donations. Clinics are maintained for European and native infants.

#### 15. THE UNITED STATES

Maternal mortality in the United States birth registration area is high; in 1927 61.9 per 10,000 live births. The death-rate of infants under a year was 64.0 per 1,000 live births, the mortality from intra-

natal and pre-natal causes (33.7) actually accounting for more than half the total.

The maternal death-rate amongst the Negroes is 77 per cent. greater than the White in urban areas, and 80 per cent. greater in rural; this excess is ascribed to ignorance, poverty and neglect. The higher mortality rate amongst White mothers in America than in Europe is attributed to lack of skilled attention in inaccessible areas, poor training of doctors, and high rate of self-induced and criminal abortion.

Mother and infant welfare work, as an activity of the State Department of Health, has mainly grown up since the war. By 1925 practically every State had taken up the question, and forty-three States were receiving Government grants.

Midwives are discouraged in some States, but they practise nevertheless, and especially in the Southern States and amongst the Negroes, the intervention of untrained women is a serious matter. Only twenty-seven States require midwives to be licensed, and only twenty-nine give any instruction or supervision. In twelve cities midwives are legally debarred from practising.

Anna E. Rude, M.D., Director of Maternal and Infant Hygiene to the U.S. Children's Bureau, reported in 1893<sup>1</sup> that the supervision of midwives and the erection of educational standards for them was tending to reduce the number of midwives. In New York City the number had been reduced in ten years from 3,000 to 1,600. In Richmond, Virginia, when regulations governing the practice of midwives were adopted in 1921, weekly classes followed by an examination were given to eighty midwives, but only forty-seven could be accepted for registration. In Birmingham, Alabama, in 1920, classes were instituted for the licensed midwives.

<sup>1</sup> Paper read before the Seventy-fourth Annual Session of the American Medical Association.

"After a discouraging year" it was decided to eliminate the midwife as far as possible.

Though the maternal mortality rate, and especially the rate of puerperal sepsis, is high as compared with other countries (see Appendix, p. 203), yet the rate for New York City is amongst the lowest, and New York comes second in order of merit amongst the cities given by Dr. Janet Campbell,<sup>1</sup> being beaten only by Copenhagen. The maternal death-rate of New York State was 6.0 per 1,000 live births in 1927, the White rate being 5.8,<sup>1</sup> and the Coloured 12.5—a truly appalling figure. In Florida the Coloured rate was higher still, 15.6 per 1,000 births. Infant mortality in New York State was 57 per 1,000 births White and 109 Coloured.

In New York State 90 per cent. of the births are registered by physicians, 9.5 per cent. by midwives, 5 per cent. by others. In New York City 26 per cent. of the births are attended by midwives. Midwives throughout the State are licensed and supervised by the Health Department with the co-operation of local Health Officers and Public Health nurses. Quarterly letters of instruction to midwives are sent out, inspections are made, and lectures and group instruction are given to them.

The New York City Bureau of Maternal and Infant Welfare was the first of its kind in the United States. Ante- and post-natal clinics cover the city.

The following rules for maternal care by medical practitioners, adopted by Regional Consultants in Obstetrics for the New York State Department of Health, provide a model worthy of universal consideration:

*Pre-natal.* Continuous medical supervision should begin as soon as the mother suspects pregnancy.

<sup>1</sup> *The Protection of Motherhood*, Ministry of Health, 1927, p. 13.

“Hospital care should be advised, when indicated and available, for all parturients (particularly primiparæ), and should be insisted upon for all abnormal cases.

“First visit should include: Histories of previous pregnancies and labours. Determination of expected date of confinement. Instruction in the hygiene of pregnancy, including diet, elimination, exercise, rest, clothing, care of the breasts preparatory to breast-feeding, marital relationship and provision of literature on pre-natal and infant care.

“Physical examination should be made as early in pregnancy as practicable. Special attention should be directed to determination of blood pressure. Urinalysis. Heart, lungs, kidneys. Thighs, legs and vulva for varicosities. General nutrition. Posture with examination for spinal curvature, subluxation of sacro-iliac joints or other abnormality. Blood, Wassermann when indicated. Pelvic examination. Palpation of bony pelvis. Pelvimetry; the following measurements being suggested: interspinous, intercrystal, external conjugate, external obliques, internal conjugate (estimated), transverse of the outlet, posterior sagittal.

“Classification as to type of pelvis.

“Vaginal examination, preferably after the first six weeks if there are no indications of abnormalities.

“Instruction of the patient to report promptly the following symptoms: headache, nausea, dizziness, visual disturbance, epigastric pains, bleeding, constipation, œdema.

“Frequency of visits. The patient should visit her physician at least once a month until the sixth month, then every two weeks or oftener as indicated, preferably every week in the last four weeks. Local nurses and social workers could be utilised

to follow up patients if they do not return at the appointed time.

"Subsequent visits should include:—Determination of blood pressure. Urinalysis. Examination for fœtal heart. Any other examination that may be indicated. Determination of presentation and engagement and probable position of the fœtus after the seventh month. Vaginal examinations should not be made after the seventh month unless indicated. If made they should be conducted under the same aseptic precautions as for delivery. Rectal examinations will usually furnish necessary information.

"Instruction of the patient in: preparation of person, room, outfit for confinement and for the baby. This may often be given by the patient's nurse or by the local visiting or community nurse at the physician's request.

#### *Delivery.*

"Time should be given freely.

"Consultant facilities should be available. As any abnormality requires more than average experience it should not be handled without the advice of a consultant obstetrician.

"Nursing care should be adequate.

"Equipment sufficient to meet emergencies should be accessible.

"Surgical cleanliness. Rubber gloves, sterilised by boiling or steam pressure, should be used for examinations and delivery.

"The vulva should be shaved and the entire field cleaned and made and kept aseptic.

"Vaginal examinations should be avoided if possible. Usually confirmation of previous findings can be made and progress satisfactorily followed by rectal and abdominal examinations.

“Indications for interference, the cervix being fully dilated or dilatable and no other abnormality being present:—Failure of labour to progress. Fœtal heart rate below 100 or above 170.

“Should radical interference become necessary, the same careful surgical technique should be used as when entering the peritoneal cavity.

“Examination after delivery should include: the perineum and vaginal outlet for evidence of lacerations, which should be repaired immediately.

“The placenta and membranes to see if they are complete. The uterus by external palpation to see if it is empty and firm. Time should be taken to examine the baby thoroughly and to give full directions for the care of both patients.

“Hæmorrhage:—Normal contractions of uterus, determined by abdominal palpation should be maintained for at least one hour after it is emptied. In event of persisting hæmorrhage immediately after delivery which does not yield to ordinary measures the fundus should be massaged through the abdominal wall. If bleeding continues the cervix may be examined for laceration and necessary repairs made.

“Freshly sterilised gauze for packing should be available.

#### *Puerperium or Post-partum Period.*

“The patient should be seen by the obstetric attendant as often as may be needed.

“Post-partum visits should be made at least, on first day, to determine uterine contraction, bladder tone, to establish breast-feeding and note general condition of the patient.

“Third and fifth days, to determine possible evidence of infection and not involution.

“Tenth day, to determine involution, general

## THE CARE OF MATERNITY 181

condition of patient and to fix the time when mother may sit up.

"A final bimanual examination should be made about six weeks after delivery or before the patient resumes usual activities, to determine displacements, subinvolution, cervicitis, resolution of lacerations with correction of defects.

"The patient should remain in bed at least ten days after delivery.

"She should not resume full activities for six weeks after delivery, as it takes six to eight weeks for complete involution to take place.

"The services of a visiting or community nurse may be secured if available for the after-care of patients if such service is desired."

There is no maternity insurance or bounty in the United States. Upwards of forty States grant children's allowances (generally called Mothers' Pensions) to deserted and divorced wives and wives whose husbands are unable to support them, in order that they remain at home to care for their children (in a few States these allowances are made also to unmarried mothers).

CHAPTER FIFTEEN  
LETTERS ON MATERNITY

From George Bernard Shaw; The Right Hon. J. Ramsay MacDonal, M.P.; The Right Hon. Arthur Henderson, M.P.; Miss Margaret McMillan; Colonel Mansell Moullin, C.B.E., F.R.C.S.; The Right Hon. Sir John Gilmour, M.P.; R. F. Picken, Medical Officer of Health for Cardiff; Miss E. Simpson, Secretary of the Midwives' Institute; Miss Mabel Liddiard, C.M.B., Matron of the Mothercraft-Training Society; Miss Ellen Wilkinson, M.P.; Lady Cynthia Mosley, M.P.; Miss Dorothy Jewson; A Working-class Mother; An East End Mother; Sir Samuel Scott, Chairman of Queen Charlotte's Hospital; A Practising Midwife; Eric Pritchard, M.A., M.D., F.R.C.P.

GEORGE BERNARD SHAW

Mr. Bernard Shaw wrote to me:

"Somebody ought to investigate the curious statistical fact that the poor, who have a much higher infant mortality than the rich, have a lower maternal mortality. It suggests that the slum midwife or sympathetic neighbour, who has no forceps and cannot resort to the Cæsarian operation when there is any difficulty, may be a safer help than the medical student picking up his midwifery, or even the skilled obstetrician.

"It may also be that the hospitals are better than the gentlemanly general practitioner in the private house. But somebody should take up the question in these days when doctors are taught to operate for everything."

I replied to Mr. Bernard Shaw, warning him against these statements, and citing the evidence of the United States inquiry into maternal mortality given in Chapter I, and the high mortality in certain hospitals. He replied:



20th April, 1930.  
Edstaston,  
Wem (on the road),  
Salop.

"MY DEAR SYLVIA,

Some years ago my attention was caught by a statistical statement which showed an enormous infant mortality rate at Bethnal Green (130, I think) against only seven in Hampstead, but with a higher maternal mortality rate in Hampstead than in Bethnal Green. This anomaly stuck in my memory and connected itself with cases which I saw of well-to-do mothers enormously overfed on rest-cure lines, wallowing in beds saturated with milk (or so they seemed), and also with statements made by obstetricians that forceps marks on heads, detectable by experts, are now common. My doctor-uncle regarded the forceps as something to be used only in the last extremity, and denounced the young men who used it as a matter of course, just as they used a knife and fork at table. Then within the last few years came the complaints from America, that the large fees obtained for operative surgery have produced a race of accoucheurs who can use scalpels but cannot use their hands, with the result that unless the birth is practically spontaneous, they resort to the Cæsarian operation, and even preach that this is the civilised and proper method of delivery.

"Of course the question is muddled as usual by the probability that 90 per cent. of the cases, both infantile and maternal, are poverty cases; so that it seems hopeless to attempt to extract the medical cases. The figures you quote in your letter are, as you say, senseless. But as Katherine Mayo made such a sensation with the obstetric parts of her book on India, it seems possible that a book by you exposing obstetric savagery and superstition in the British Isles might attract some attention. The Indians, at least, would appreciate it. —

“It is a pity that the subject does not lend itself to filming. I saw a Russian film the other day which greatly extended my conception of the propagandist power of the screen.

“Faithfully,  
“G. BERNARD SHAW”

FROM THE LABOUR PRIME MINISTER

10, *Downing Street,*  
*Whitehall.*  
18th March, 1930.

“DEAR MISS PANKHURST,

I have had your letter informing me that you are preparing a collection of opinions on the question of Maternal Mortality. This is one of the most important questions of the day, and is surrounded by a certain amount of obscurity. The Government are giving every possible assistance to those whose labours will, we hope, be completely successful in putting an end to this preventable suffering and grief which make a peculiar appeal to the whole of our people.

“Yours very sincerely,  
“J. RAMSAY MACDONALD”

FROM THE FOREIGN SECRETARY IN THE LABOUR GOVERNMENT AND SECRETARY OF THE LABOUR PARTY

*Transport House (South Block),*  
*Smith Square,*  
*London, S.W. 1.*

“DEAR MISS PANKHURST,

I have looked with much interest through the proposals you are putting forward dealing with Maternal Welfare. For many years past this question has been constantly before the Labour Party, and it is one of the subjects on which we hope that we soon shall be able to take effective action. The main lines we have

followed are similar to those which you suggest. A complete scheme must ensure for the mother fully qualified medical and nursing care. She must also be relieved of any household worry, both by provision of help in the home and by some financial help such as that of the maternity benefit given under National Health Insurance.

“Speaking in general terms, I would say what we aim at is a National Maternity Service, in which the work of the Public Health Authority and the service under National Health Insurance shall be linked together in close co-operation. Our object is not only to prevent the present wastage of life, but to secure good health for those many more thousands of mothers and babies who are now left to suffer, perhaps for the rest of their lives, through insufficient care at childbirth.

“I have not dealt in detail with your proposals, but may say that we welcome all help in rousing public opinion on these general lines.

“Yours sincerely,

“ARTHUR HENDERSON”

FROM MARGARET McMILLAN, THE GREAT EDUCATIONIST AND NURSERY SCHOOL PIONEER

“Your suggestions are admirable. The homes are in many cases quite unfit for the events of birth, and there it is difficult to make adequate proposals.

“Maternity Homes are for many the only solution.

“Yours truly,

“MARGARET McMILLAN”

FROM A GREAT SURGEON, COLONEL MANSELL MOULLIN,  
C.B.E., F.R.C.S.

"DEAR MISS PANKHURST,

I quite agree with you that something should be done to lower the disgraceful death-rate of maternity. I hope you will succeed in rousing the country, but people are very indolent, and hate being stirred up. They always want to let things slide.

"Yours sincerely,

"C. MANSELL MOULLIN"

FROM THE EX-SECRETARY OF STATE FOR SCOTLAND,  
THE RIGHT HON. SIR JOHN GILMOUR, M.P.

"I recognise the importance of the problem, and believe that during the period when I was the Minister responsible for the Health Department in Scotland, material progress in improving these services was made.

"JOHN GILMOUR"

FROM A MEDICAL OFFICER OF HEALTH, RALPH M. F.  
PICKEN, M.B., CH.B., B.Sc., O.P.H.

"I agree generally with the proposals made in the report of a Departmental Committee on the Training and Employment of Midwives submitted to the Minister of Health on 10th July last. I think, however, that it is desirable that any further legislation with this object should enable Local Authorities, without detracting from any other provisions made, to provide in urban

areas a more highly organised type of service for midwifery. It would, I think, make for a reduced maternal mortality if Local Authorities were empowered to provide a maternity service, which included hospital bed accommodation, ante-natal clinics, and a staff of medical men, including consulting obstetricians and midwives working in close conjunction with the hospitals and clinics. These proposals would merely make for co-ordination of something which already exists in most big towns. We have hospitals, most of which are either maintained by the Local Authority or subsidised by it, we have ante-natal clinics on a similar footing, we have staffs of district midwives under the Queen's Institute of District Nursing, we have a system of supervision of midwives by the officers of Local Authorities, we have Poor Law district medical officers, who are responsible for the confinement of women in receipt of public assistance, and we have consulting obstetricians who may be called in at the public expense to assist in the diagnosis and treatment of women suffering from the infections of the post-natal period. A proper co-ordination of these services would, I believe, make for efficiency. It is, of course, obvious that any scheme should leave a woman absolutely free to go to practitioners outside any such municipal service, but there is no reason why both types of provision should not run concurrently in towns. The records of the extern department of maternity hospitals and of the Queen's Institute of District Nursing show how satisfactory the results of a properly organised service may be.

“RALPH M. F. PICKEN”

FROM THE SECRETARY OF THE MIDWIVES' INSTITUTE  
(Founded 1881, Incorporated 1889)

“The question of maternal mortality and morbidity is occupying the minds of thoughtful people at this moment, whether they have had little practical experience of the matter or are well qualified by knowledge and practice to speak on it.

“No one has yet propounded a solution and we do not really know why women die in childbirth, and shall not know until there is a post-mortem by an independent and competent obstetrician on every case. This is the opinion of the Midwives' Institute, which has closely followed the question for forty years.

“E. SIMPSON”

FROM THE MATRON OF THE MOTHERCRAFT TRAINING  
SOCIETY, MISS MABEL LIDDIARD, C.M.B.

“It is difficult to ascribe any one cause to the high maternal mortality and morbidity of this country, as there are probably a large number of contributing factors. It is generally recognised that unnatural and prolonged labours are among the causes of sepsis; general low health and poor resistance increase this, whilst rickets in childhood is a direct cause of unnatural labour.

“As to measures which should be taken to reduce the above, in my opinion *education* on the subject stands first—the general public must be given a right outlook and be made to realise the importance of general health and of proper ante-natal care. Doctors and nurses should have the best possible training and be made to understand the importance of the preventive aspect.

"I do not think the remedy would be the provision of more maternity homes except for abnormal cases. Child-bearing should be made as natural and normal as possible, and the mother is usually happiest in her own home with her family. At present, housing and social conditions make this difficult, but the ideal remedy would seem to be to provide proper houses and sufficient help while the mother is in bed.

"M. LIDDIARD"

FROM MISS ELLEN WILKINSON, M.P.

"The real difficulty in the whole of our Maternity and Child Welfare work is that the Act of 1918 is a permissive measure. It *allows* the Local Authority to set up a service of Health Visitors, Ante-Natal Clinics, Maternity Homes, Home Helps, provision of food and milk during the last three months of pregnancy and during lactation. It can provide, if necessary, for nursing at home, and also it can assist District Nursing Associations to provide Convalescent Home treatment. But there is no compulsion about it, and while voluntary effort has done a great deal towards rousing the authorities to a sense of their responsibility, nothing short of making it compulsory for every Health Authority to prepare a complete scheme for maternity work can tackle the appalling problem we have to consider. Such a scheme ought not to be considered satisfactory unless it provides for sufficient Ante-Natal Clinics to enable all pregnant women to seek advice, and sufficient maternity beds for all women whose confinements are likely to be difficult, or whose home conditions make proper care at home impossible. These schemes should be linked up with the extension of medical benefit to the wives of all insured persons and the administration of that benefit by the Local

Authority. I am convinced that if we had prepared statistics of the health of married women, the sickness rate of the wives of manual and lower middle-class workers would be shown to be alarming. The best scheme could never be satisfactory unless it included the provision of food for mothers who are in need. In the present state of industrial depression many women literally starve themselves in order that the breadwinner and the young children should have whatever food there is going. I have known women who for months before the baby came had little more food than bread and margarine with tea and skimmed condensed milk. This leaves them without the strength to feed the children or face the strain of their confinement. The Boards of Guardians have, in many cases, been very remiss in giving extra food to pregnant mothers, and when they have done so, they have often taken it off the food given to the family, which, of course, puts the mother in a very difficult position. I remember that during the war many towns provided mid-day meals for nursing and pregnant mothers and saw that they ate them. I am sure that this did a great deal towards reducing mortality rates in those areas."

FROM LADY CYNTHIA MOSLEY, M.P.

"I am interested in the subject of maternal mortality, and I feel that this serious state of affairs calls for a wide extension of the provision made for expectant mothers, that medical and nursing care should be supplied both before and after child-birth as an essential part of the National Insurance Scheme. Given such facilities widely known and appreciated, I am sure the rate of maternal mortality will inevitably decrease.

"Yours sincerely,

"CYNTHIA MOSLEY"



## FROM ONE OF THE EARLIEST WOMEN M.P.'s.

"It is time something drastic were done. In Norfolk 186 parishes have no arrangements whatsoever for the supply of a midwife, and in the rest they rely almost entirely on voluntary organisations.

"All manner of private maternity homes are now receiving large Government grants where the inspection is merely nominal and control nil. All homes receiving grants should be run under the control of the local Council and the work co-ordinated.

"I would develop the staff of doctors employed by the Councils for maternity cases.

"DOROTHY JEWSON"

## FROM A WORKING-CLASS MOTHER

"When I found I was to have another baby with *three others* and an adopted orphan niece in addition, I must confess I was very much depressed, as it meant to me, who was already overworked, months of weariness, and at the end of it all agony for the best part of twenty-four hours, and then another child to maintain *without any State allowance*. I was not able to go away into a lying-in home and so had to depend on 'a motherly woman' to superintend my home affairs; one of the type who has had ten and buried eight and so feels 'experienced.' For this I had to pay 15s. weekly, and 6d. twice a day beer money. The same experience prevailed as before—nothing economical was going on and I was glad for maternity benefit to come along, *not to buy luxuries*, but ordinary everyday necessities and pay my way, as, in spite of nine months' expectancy, there is not sufficient earned to provide all one would like. As the child was born at ten o'clock at night, the 'nurse' considered this one day, with the result I was sitting up on the ninth day instead of the tenth, which is considered to be suitable after a normal case."—D. P.

## FROM AN EAST END MOTHER

"I was married at the age of nineteen years. My mother was dead and I had the care of a younger brother and sister aged thirteen and sixteen years. After being married a year I had my first child. I could not afford to have a woman in, so my young sister (then aged fifteen) looked after the house for me and a woman took away the washing. Nurses from the local Maternity Centre attended me during the birth of the child. As I was more or less ignorant on these matters I did not care for myself as I should have done, either before or after the confinement. I soon began to suffer a great deal from bronchitis and neuralgia. Not having enough nourishment had a great deal to do with my poor health, for my husband fell out of work.

"When I had the second child, two years later, although everything was normal when the child (a 10-lb. boy) was born, three weeks later I had to go back to bed for general debility and could not lift the child to feed him. This was caused by overwork. I had the washing to do for nine people and two hairdressers' shops. This also caused prolapse of the womb. The child cried more or less continually until he was six months old. My husband then got work and things were a little easier.

"Two years later the third child was born, a boy. With him were two still-born children. The prolapse of the womb and neuralgia were worse this time, owing to weakness, and sometimes I did not go to bed at night, but sat in a chair because of the pain.

"My husband and I then began to study birth control, and it was three years and seven months before the next child was born. Prolapse of the womb lasted for twelve months after this one.

"Twelve years elapsed before the next birth. With any overwork of washing or scrubbing I still suffer from

the prolapse, and I am now forty-six years of age. I find rest is the only cure for it, and as I work seven days a week, I can only get a little rest by having a woman in for scrubbing or washing to save the worst strain.

"I had no medical attention when I most needed it, for I could not afford it. Now I do not trouble. I have seen a doctor about three times in my life.<sup>1</sup>

"No working-class mothers have enough care taken of them either before or after the birth, and it says a great deal for their courage and perseverance that the children do not suffer more than they do.

"As a healthy nation is the ideal, it should be accepted as a national charge at this stage of civilisation to care for the mothers and babies. It is a *national responsibility* and *the most important thing in the world*. *Healthy minds in healthy bodies* will make for the highest point of *Happiness and Efficiency*."

FROM THE CHAIRMAN OF QUEEN CHARLOTTE'S HOSPITAL,  
SIR SAMUEL SCOTT

"Though mothers die from various causes, it is a well-known and established fact that puerperal fever is responsible for nearly half of all maternal deaths after childbirth. The medical profession has not at present the necessary knowledge either to prevent this disease or control it when it occurs. Until this knowledge has been acquired there will be no diminution in the rate of mortality from this cause. Owing to the infectious nature of the disease, cases of puerperal fever are scattered, so that up to the present no one investigator has in his hands sufficient material to enable him to carry on the continuous and intensive research of the particulars of the disease requisite to gain the precise

<sup>1</sup> The writer of this letter has since been operated upon for a disability of many years standing and is making a slow recovery.

knowledge so urgently needed. The main necessity at present is opportunity for scientists to carry out the research necessary. This opportunity will shortly be given when Queen Charlotte's Isolation Hospital for septic maternity cases, the first ever to be erected, and a fully-equipped laboratory for research, now in course of erection, are completed. No doubt some cases of maternal mortality are due to the fact that the medical attendant has not either the necessary practical knowledge or facilities to deal with cases of abnormal labour. A student during his training may have had no opportunity of having practical experience in any cases other than normal, and, therefore, must entirely depend upon the theoretical knowledge he may have acquired. It is extremely difficult for medical students and post-graduates to obtain the necessary practical knowledge, and I have no solution of this difficulty to offer. I am sure, however, that it will be possible to give a more intensive training in maternity work to medical students and post-graduates than they have at the present moment, when the large new Queen Charlotte's is built, for it will not only itself offer increased facilities for learning, but its example, as a teaching centre, will almost certainly stimulate a wider and better training in other hospitals. The better training of the student will have a marked effect on the maternal death-rate. The main cause of maternal mortality still remains, namely, puerperal fever, and maternal mortality will not materially decrease until medical science has obtained the knowledge necessary to deal with it.

"SAMUEL SCOTT"

#### FROM A PRACTISING MIDWIFE

"As a practising midwife of some years' standing, I do not fully agree with the proposals of the Medical Women's Federation. I find that the general medical

practitioner has not the time, nor, unfortunately, the inclination for ante-natal work. The midwife, who already works a good many hours per day, cannot do more than she does, however willing she may be. I think myself that if the midwife had to depend solely upon the general practitioner, she would find herself in greater difficulties than at present.

"I think a great deal might be done as follows:

"1. Make the midwife a municipal servant and thus assure her a definite income, regular hours of duty, and relief for holidays, etc. At present she cannot obtain adequate rest, and obviously she is scarcely able to do her best after perhaps thirty-three hours on duty.

"2. Set up an expert medical service, including ante-natal and mother and infant clinics within easy reach of midwife and patient, and at least two attendances per week of a qualified obstetrician, and if necessary a specialist. Although the midwife is trained to give ante-natal care to her patients, I consider the expectant mother should also be examined by a doctor, as so much general disease affects pregnancy, labour and the puerperium.

"3. Efficient medical service should be available as required during the delivery without the hours of waiting, dangerous both to mother and baby, when the general medical practitioner cannot be obtained. This happens only too often.

"4. A good service of municipal 'home' helps reasonably paid, and medically examined in case of varicose ulcers and septic foci, etc.

"5. Last, but not least, an efficient means of obtaining adequate nourishment of the expectant mother three months before the birth and as long afterwards as possible. This is necessary, not only where the husband is out of work, but where he earns exceptionally low wages, or there is a large family, or the patient is anæmic or weak."

## MATERNAL MORTALITY

By ERIC PRITCHARD, M.A., M.D., F.R.C.P., Medical Director of the Infants' Hospital, and Pediatrician to Queen Charlotte's Hospital.

On the subject of the mortality or morbidity connected with childbirth I cannot speak with the authority of an expert. I know, however, that something like 3,000 lives are lost every year among parturient women, and that this loss represents only a small fraction of the penalty which the mothers in this country pay for the privilege of maternity. I know also that this loss is quite incommensurate with the suffering inflicted on some 3,000 devastated homes, and in this connection, and from its indirect influence on infant mortality, I naturally take the deepest interest in the subject.

It is a rather curious reflection on the progress of obstetric practice and maternity service, that although infant mortality has been reduced by more than 50 per cent. during the last thirty years, and although the general death-rate both amongst men and women has materially improved, the maternal death-rate has if anything slightly increased during the same period.

Without a knowledge of the causes of maternal mortality it is hardly to be expected that we can devise means by legislation or otherwise to combat it. Do we know what these causes are? The answer is, we know some, but not all. The Registrar-General's Report for England and Wales showed that during the year 1927, no less than 2,690 women died in childbirth, which gives a mortality rate of 4.11 per thousand births. In 1908 the corresponding rate was 3.5, and for 1923 3.81.

Of the deaths in 1927, no fewer than 1,026 were due to puerperal fever—*i.e.* to sepsis or streptococcal infection. Deaths due to toxæmia came second in the list, and those due to hæmorrhage third. Deaths due to these causes are within limits preventable.

In the first place, puerperal fever can either be reduced to a minimum by a strict application of the general principles of "asepsis" in the surgical sense—*i.e.* by up-to-date midwifery, or anticipated by the bacteriologist, who can immunise women susceptible to the hæmolytic streptococcus which is the specific germ of puerperal fever. Liability of this kind to infection can be proved in advance by a simple and harmless bacteriological test, and if found can be countered by an inoculation of vaccines. The toxæmias of pregnancy which are responsible for quite a considerable number of deaths during the puerperium period can be detected before confinement by clinical examination of the pregnant woman before they reach serious dimensions. Finally, the hæmorrhages of childbirth seldom prove fatal in the hands of skilled obstetricians.

Although there is clearly room for patient research work to discover exactly the conditions in pregnant women which favour the development of sepsis, and although we know little about the effects of attempted though unsuccessful abortion, we clearly know enough to prevent the major part of the mortality, if only the knowledge which we possess were put into practice. Nearly all authorities are agreed that the chief preventive means lies in the provision of an efficient service of adequately trained midwives, who can refer in case of need to a staff of expert obstetricians,<sup>1</sup> and such service must be supplemented with a system of ante-natal examination of all expectant women. In addition, there must be a sufficient number of institutional beds for complicated cases and for women whose housing conditions make childbirth dangerous or difficult in the home.

In order to attract the right sort of women into the

<sup>1</sup> In my opinion, the expert obstetrician should be present at the birth and visit during the puerperium, the midwife acting under him.—E. S. P.

maternity service the remuneration must be higher than it is at present, but since all evidence goes to show that the safest way to conduct normal childbirth is in the home with a skilled and conscientious midwife in attendance, in the long run the expenses of an improved service of this kind will be the most economical. The initial expenses of such a service must necessarily be high, consequently they must be borne either by the municipality or the State. It should form part of the Public Health Department, and perhaps be supported by maternity benefits under the National Health Insurance Scheme.

The prevention of maternal mortality, like that of infant mortality, is not, and cannot be, cheap. Indirectly, however, it may be exceedingly economical. What is needed at the present time is to make all classes of society understand the true economy of preventive means in general—not in respect to maternal mortality only, but in respect of mortality and morbidity of both sexes and at all ages. We spend something like one hundred million pounds per annum in attempting to cure disease—generally a vain task—but it would be better to spend a half or less of this sum in preventing it. To educate the public it is necessary to resort to propaganda schemes on a large scale. In a small way, such means have been very successful as carried out by the National Baby Week Council in educating the public to view with complacency the spending of very large sums of public money on child welfare schemes which would never have been contemplated twenty years ago. The same sort of propaganda work, but on a larger scale, is required to teach the public to view with equanimity large expenditures on the prevention of maternal mortality.



## SOME PUBLIC UTTERANCES ON MATERNAL MORTALITY

By the Rt. Hon. Stanley Baldwin, M.P.; the Rt. Hon. Arthur Greenwood, M.P.; F. W. Pethick Lawrence, M.P.; Miss Susan Lawrence, M.P.; S. G. Moore, M.D., M.R.C.P., D.P.H., Medical Officer of Health for Huddersfield.

THE EX-PRIME MINISTER THE RT. HON. STANLEY  
BALDWIN, M.P.

“I take a very deep interest in the subject of maternity. There is nothing in the country that makes for its happiness, the health of the rising generation, and the health of woman in her later years, comparable to seeing that proper care is taken of her in her confinement. A great physician told me quite recently that if this were done in every case you might close half the women’s hospitals in the country. . . . We have come to the conclusion that maternity benefit under the National Health Insurance Act is not at present being expended to the best possible advantage. The present rate of maternal mortality and the amount of sickness among mothers point, in our view, to the need for the re-organisation of this provision. Proposals are, therefore, under our consideration for making available to insured women, and to the uninsured wives of insured men, proper medical and midwifery services during pregnancy and childbirth, in addition to providing some cash payment on confinement.”—*Speech at Drury Lane Theatre, April 1929.*

THE MINISTER OF HEALTH IN THE LABOUR GOVERNMENT,  
THE RT. HON. ARTHUR GREENWOOD, M.P.

"I hope I may be privileged before I leave my present position to have done something to strengthen the whole service relating to maternity and infant welfare."  
—*Presidential Address to fifth English-speaking Conference on Maternity and Infant Welfare, July 4, 1929.*

THE PARLIAMENTARY SECRETARY TO THE MINISTER OF  
HEALTH, MISS SUSAN LAWRENCE, M.P.

"For every 2,000 babies born in this country nine mothers die. Some countries, however, are better than others, and in this fact there is hope, for there would be great changes if Local Authorities looked after their mothers. In West Ham, one of the worst areas in the country, they have at least helped the women so that the maternal mortality rate is only  $2\frac{1}{2}$  per cent. . . . Women must realise that they are all-powerful, and then they will get things done."—*Speech at Nottingham, January 9, 1930.*

F. W. PETHICK LAWRENCE, M.P., PARLIAMENTARY  
SECRETARY TO THE TREASURY

"The question of maternal mortality is a very serious one indeed. We realise the grave loss of life that is due to industrial accidents. Every year there is a terrible toll of life in the mines. There are those who lose their lives on the railways. . . . There are those who are victims of other industrial accidents; but when you add those altogether, the total is less than the number of women who lose their lives in childbirth every year."—*Speech on the Local Government Bill, House of Commons, November 27, 1927.*

"I vigorously opposed the cut in the name of

'economy' on the resources of Health Insurance, thereby preventing the Approved Societies from improving maternity benefit as they had intended to do. In my view wholly inadequate provision is made for looking after women in childbirth."—*To the Electors of Leicester, May 1929.*

### FROM A MEDICAL PIONEER

The British College of Obstetricians and Gynæcologists is engaged in drawing up a National Maternity Scheme at the request of the Minister of Health. To obtain information in support of its views it addressed a questionnaire to Medical Officers of Health. Dr. Moore of Huddersfield replied as follows:—

*Public Health Department,  
Huddersfield.  
6th May, 1930.*

"MY DEAR SIR,

*"National Maternity Scheme Questions.*

"It will give me satisfaction to do what I can to answer your questions.

"I want to refer to question Number 8—'Are there any ante-natal clinics or beds within the Institutions mentioned?' The answer is 'No!' But were I to leave the thing there it would create an entirely false impression. Whoever drew up the list of questions followed a well-known regrettable aptitude of men during the present times.

"Any old 'cult,' 'stunt,' 'vogue,' 'fashion' tends to be accepted as the normal, and only, aspect of a subject which need be considered.

"There is no ante-natal clinic in Huddersfield, nor will there ever be as long as I have any say in the matter. True, it makes the job of the medical officer easy and dignified. To examine women in a Clinic—clean,

ventilated, warmed, lighted, with one or more satellites in attendance—is one thing. The task commences to wear a different aspect if it is carried out in the place where it ought to be done, namely, in the homes of the people—often dark, smelly, dirty, ill-ventilated and so on.

“And there are the journeys there in all sorts of weather—the wind, the sleet, the hail, the snow of the winter, and the dusty heat of summer. In the name of common-sense, who ought to endure these things—the woman on whom motherhood is impending, or the person appointed to render to her service? . . .

“The medical officers who see women in ante-natal clinics are never properly trained to appreciate the real state of affairs. That can only be done by personal visits to the homes, where the mothers and their infants must live, both before and after the confinement.

“To argue that this latter work can be done by nurses is simply to affirm that the second-best is good enough for motherhood. I will never agree to that.

“The subject has been under my consideration for a number of years. I started a system for the voluntary notification of pregnancy in 1916.<sup>1</sup> At the present time 50 per cent. of pregnancies in Huddersfield are notified to me. Where reliance is put on clinics the numbers who receive the ministrations of the Department are more like 5 per cent. of the total.

“Faithfully yours,

“S. G. MOORE, M.F., M.R.C.P., D.P.H.,  
“Medical Officer of Health.”

<sup>1</sup> See Chapter VII, pp. 88–90.

## STATISTICAL APPENDIX

### MATERNAL MORTALITY IN VARIOUS COUNTRIES From the Annual Report of the Director-General of Health for New Zealand, 1929.

The following table gives the death-rate from puerperal causes in various countries (a quinquennial average—such an average discounts annual extremes):

Country	Period	Date-rate per 1,000 Births from—		
		Puerperal Septicæmia	Other Puerperal Causes	All Puerperal Causes
Sweden . . . . .	1920-24	1·15	1·36	2·51
Italy . . . . .	1922-26	1·02	1·52	2·54
Netherlands . . . . .	1923-27	0·59	2·03	2·62
Norway . . . . .	1921-25	0·74	1·91	2·65
Uruguay . . . . .	1922-26	1·67	1·01	2·68
Denmark . . . . .	1922-26	0·95	1·81	2·76
Hungary . . . . .	1922-26	1·43	1·57	3·00
Japan . . . . .	1921-25	1·21	2·07	3·28
England and Wales . . . . .	1923-27	1·48	2·52	4·00
Germany . . . . .	1921-25	2·80	1·47	4·27
Spain . . . . .	1922-26	2·25	2·09	4·34
Switzerland . . . . .	1922-26	2·07	2·57	4·64
Irish Free State . . . . .	1923-27	1·67	3·05	4·72
New Zealand . . . . .	1924-28	1·86	2·89	4·75
Northern Ireland . . . . .	1921-25	1·55	3·21	4·76
Union of South Africa . . . . .	1923-27	2·03	2·96	4·99
Australia . . . . .	1923-27	1·84	3·65	5·49
Belgium . . . . .	1921-25	2·68	2·85	5·53
Canada . . . . .	1923-27	1·80	3·98	5·78
Scotland . . . . .	1923-27	1·78	4·47	6·25
Chile . . . . .	1922-26	1·69	4·98	6·67
United States . . . . .	1920-24	2·54	4·36	6·90
Trinidad . . . . .	1923-25	3·58	5·68	9·26
British Guiana . . . . .	1922-25	2·68	11·55	14·23
Ceylon . . . . .	1923-27	7·40	11·75	19·15

MATERNAL MORTALITY IN ENGLAND AND WALES,  
1911-28

Year	Births registered	Deaths of Women classed to Pregnancy and Child-bearing		Deaths of Women not classed to Pregnancy and Child-bearing but returned as associated therewith	
		Rates per 1,000 births registered			
		No.	Total Puerperal Mortality	No.	Total Maternal Mortality
1911	881,138	3,413	3·87	909	4·91
1912	872,737	3,473	3·98	848	4·95
1913	881,890	3,492	3·96	803	4·87
1914	879,096	3,667	4·17	831	5·12
1915	814,614	3,408	4·18	881	5·27
1916	785,520	3,239	4·12	739	5·06
1917	668,346	2,598	3·89	638	4·84
1918	662,661	2,509	3·79	2,529	7·60
1919	692,438	3,028	4·37	1,337	6·30
1920	957,782	4,144	4·33	1,086	5·46
1921	848,814	3,322	3·91	925	5·00
1922	780,124	2,971	3·81	1,051	5·16
1923	758,131	2,892	3·81	764	4·82
1924	729,933	2,847	3·90	849	5·06
1925	710,582	2,900	4·08	759	5·15
1926	694,563	2,860	4·12	709	5·14
1927	654,172	2,690	4·11	861	5·43
1928	660,267	2,920	4·42	790	5·62

CAUSES OF MATERNAL DEATH  
 From the Annual Report of the Chief Medical  
 Officer of Health, 1928

Cause of death	All ages	15-	20-	25-	30-	35-	40-	45 and upwards
Abortion . . . . .	77	2	3	15	24	21	10	2
Ectopic gestation . . . . .	86	—	8	13	29	26	6	4
Other accidents of pregnancy . . . . .	106	2	16	25	23	23	13	4
Puerperal hæmorrhage . . . . .	331	—	41	69	83	74	58	6
Other accidents of childbirth . . . . .	331	5	42	83	75	77	46	3
Puerperal sepsis . . . . .	1,184	32	202	325	269	248	101	7
Phlegmasia alba dolens not returned as septic . . . . .	31	1	3	3	10	11	2	1
Puerperal embolism and sudden death . . . . .	188	—	21	45	50	45	24	3
Puerperal nephritis and uræmia . . . . .	132	6	14	30	30	35	14	3
Puerperal albuminuria and Bright's disease . . . . .	46	2	6	9	12	10	7	—
Puerperal convulsions . . . . .	379	25*	75	99	70	68	39	3
Childbirth not assignable above (Puerperal insanity) . . . . .	21	1	4	10	3	3	—	—
Puerperal disease of the breast . . . . .	8	—	1	4	1	1	1	—
Total . . . . .	2,920	76*	436	730	679	642	321	36

\* Including one aged fourteen years

CAUSES OF STILL-BIRTHS FROM POST-MORTEM  
FINDINGS  
In England and United States, compiled by  
Investigators

	Holland and Lane Clayton, Britain	Holland, London	Witridge Williams, Balti- more	Holt and Babbit, New York	McQuarrie, San Francisco
Total No. of Cases .	1,408	300	273	636	97
Cause.					
Complications of labour . . .	35.5	28.3	22.4	31.1	37.1
Ante-partum hæmorrhage . . .	18.8	22.3	9.9	7.4	2.0
Toxæmia of pregnancy . . .	11.1	8.6	11.7	9.9	9.2
Syphilis . . .	8.7	15.3	12.8	8.3*	15.5
Maternal diseases . . .	2.5	8.6	17.2	23.8	5.2
Placental diseases . . .	1.2				
Fœtal states . . .	10.5	5.6	6.6	3.0	8.2
Prematurity . . .	3.6	0.3	5.2	2.8	5.3
Causes unknown . . .	8.1	10.7	14.3	13.7	17.5

\* Markedly syphilitic persons were not admitted to the Sloane Hospital, New York.

Dr. Cruikshank found that of 800 infants dying within 28 days of birth, 67.5 died from causes operating during birth (Medical Research Council, 1930).



## EXPLANATION OF MEDICAL TERMS USED IN THIS BOOK

(L. derived from the Latin; Gr. derived from the Greek.)

**ABORTION** (L. *abortio*, a miscarriage). Expulsion of the fœtus before the fourth month of pregnancy. Between the fourth and seventh month such premature expulsion is called a miscarriage. After the seventh month, when the child is capable of independent existence, expulsion before term is called *Premature Birth*.

**ACCIDENTAL HÆMORRHAGE** (Gr. *haimorrhagia*; *haima*, blood; *rhegeno*, to burst). Bleeding resulting from premature detachment of the placenta before the beginning of labour.

**AMNION** (Gr. *amnion*, a vessel). The innermost enveloping membrane of the fœtus, thin and transparent and containing the *Liquor Amnii* (popularly called the Waters) in which the fœtus is bathed and by which it is protected from injury. The amnion is normally ruptured during labour.

**CÆSAREAN SECTION** (L. *cædo*, to cut). An operation in which the infant is extracted by cutting into the abdominal wall or side. Julius Cæsar is said to have been so born.

**CRANIAL STRESS**. Pressure on the cranium.

**CRANIOTOMY** (Gr. *kranion*, skull; *tome*, a cutting). Operation of breaking down the fœtal head during parturition; a sacrifice of the infant's life to save the life of the mother.

**CRANIUM** (from Gr. *kranion*). The eight bones of the skull as distinguished from those of the face.

**ECBOLIC** (Gr. *ec*, out; *ballo*, to throw). An agent stimulating the uterus to contract, thus hastening the expulsion of the fœtus in childbirth or producing abortion. Ergot and pituitrin are ecbolic drugs.

**ECLAMPSIA** (Gr. *eclampo*, to shine forth). A sudden convulsion resembling epilepsy in appearance, but due to other causes. *Puerperal eclampsia*, which occurs in late pregnancy or during or after labour, is generally regarded as due to kidney trouble, and like other forms of albuminuria is treated by dieting.

**ECTOPIC** (Gr. *ec*, out; *topos*, place). Morbid displacement. Ectopic pregnancy is pregnancy outside the uterus.

**ENDOMETRITIS** (Gr. *endon*, within; *metra*, womb). Inflammation of the membrane lining the uterus. Sometimes

caused by venereal disease, but arising also from other causes.

**EPISEIOTOMY** (Gr. *episeion*, pudenda; *tome*, incision). Incision of the vulva on one side when laceration of the perineum is imminent during labour, in order to direct the tear to one side or to relieve injurious pressure of the child on the perineum.

**ERGOT** (French, a spur). A drug prepared from the spurred or horned rye, or rather from the parasitical fungus found sometimes on the seed of the rye; long used on account of its contractile effects on the uterus in order to contract the womb after the birth and prevent *post-partum* hæmorrhage.

**FÆTUS**, also **FETUS** (L.). Unborn young of any creature (before the third month it is called the *embryo*). A fœtus becomes an infant as soon as pulmonary respiration is established, the young creature now depending for its existence on the oxygen obtained through its lungs, and not on that obtained from the placenta, or from the reserves of oxygen contained in its tissues, which may maintain it for some moments after birth. Eardley Holland urges that the term "fœtal death" should be substituted for "still-birth."

**GYNÆCOLOGY** (Gr. *gyne*, woman; *logo*, discourse). The branch of medicine dealing with the diseases peculiar to women.

**HÆMOLYSIS** (*hematolysis*) (Gr. *haima*, blood; *lysis*, solution). Destruction or disorganisation of the blood or its corpuscles.

**HYDROCEPHALUS** (Gr. *hydro*, water; *kephales*, head). Water or dropsy in the head.

**INDUCTION** (L. *in*, into; *ducere*, to lead). Bringing on or causing to occur, used to indicate that labour has been artificially brought on. It is usually done on account of some abnormal condition in the mother, or when there is disproportion between the size of the mother's pelvis and that of the fœtus which threatens to become too large for safe expulsion by the maternal passage.

**LIQUOR AMNII** (L.). The fluid within the amnion, or amniotic, sac in which the fœtus is bathed; the contents of the "bag of waters."

**LOCHIA** (Gr. *lochios*, relating to childbirth). The discharge from the womb which follows childbirth during fourteen or twenty-one days.

**LOCK HOSPITAL** (Saxon, *loc* or *loce*, an inclosed place). Hospital for venereal diseases.

- MULTIPARA** (L. *multus*, many; *pario*, to bring forth). A woman who gives birth to the second or subsequent child.
- NEPHRITIS** (Gr. *nephros*, kidney). A disease of the kidneys.
- ŒDEMA** (Gr. *oidema*, a swelling). Swelling produced by the accumulation of serum in the tissues of the body, and usually under the skin. *Phlegmasia dolens*, otherwise "white" or swollen legs, is a form of this disease common in childbirth.
- PELVIMETRY** (L. *pelvis*; Gr. *metron*, measure). Measuring the pelvis, and particularly the antero-posterior or front to back diameter of the brim, the narrow part which separates the so-called "false" pelvis from the "true" pelvis below.
- PELVIS** (L. *pelvis*, a basin). That part of the skeleton which supports and contains a part of the intestines, the urinary and the genital organs.
- PEMPHIGUS** (Gr. *pemphix*, blister). Also called *Vesicular Fever*, bladdery fever, water blebs: a skin disease characterised by blisters of various sizes, accompanied by fever, occurs in newly-born infants, and is highly contagious.
- PERINEUM** (L., Gr.). The lower part of the trunk, between the bladder and genital organs and the rectum. It is occasionally ruptured during labour.
- PHLEBITIS** (Gr. *phlebs*, vein). Inflammation of a vein.
- PITUITRIN** (L. *pituitarius*, mucus). A drug made from the pituitary gland. It increases uterine contraction in childbirth; it also retards the action of the heart and increases its force.
- PLACENTA** (L., a flat cake, from Gr. *plakos*, anything flat). A soft and spongy body which is adherent to the uterus and connects the unborn child to the mother by the umbilical cord. The placenta serves as the organ of circulation, respiration and nutrition of the fœtus. The umbilical cord arises generally from the centre of the placenta.
- PLACENTA PRÆVIA** (L. *præ*, before; *via*, a way). Attachment of the placenta to the lower portion of the uterus. At the beginning of labour this attachment is necessarily loosened and hæmorrhage or bleeding ensues. The safety of the mother depends on speedy delivery.
- PRESENTATION**. That part of the fœtus which is felt on examination by the vagina. When the head, especially the vertex or crown, or the feet, knees or breech can be felt, the presentation is said to be natural. If any other part presents itself the labour is styled "Perverse" or

- “Preternatural,” and is colloquially called a “cross birth.” In such cases the operation of turning, or “version,” is frequently performed.
- PRIMIPARA** (L. *primus*, first; *pario*, to bring forth). A woman who gives birth for the first time.
- PUERPERAL FEVER**. Septic fever occurring during the child-bed or puerperal state. Puerperal septicæmia. Jellett says: “Puerperal fever is the official misnomer for puerperal sapræmia and puerperal septicæmia. I call it ‘misnomer,’ because it is an unfortunate term that suggests that septicæmia occurring during the puerperium differs from that occurring at other times, and that it is a specific disease peculiar to lying-in women.”
- PUERPERIUM** (L. *puer*, child; *pario*, to bring forth). “Period following labour during which the woman is recovering from the effects of pregnancy, and the pelvic organs are returning to their former condition. In normal cases from six to eight weeks, but may be prolonged in those which are complicated.”—*Dictionary of Practical Medicine*, edited by Sir Malcolm Morris, F. Longmead and G. M. Holmes (Cassel & Co.).
- PYREXIA** (Gr. *Pyrexia*, feverishness; *pyr*, fire). The Ministry of Health defines puerperal pyrexia as any febrile condition occurring 21 days after childbirth or miscarriage in which a temperature of 100·4 F. has been sustained during 24 hours or has recurred during that period.
- RECTUM** (L. *rectus*, straight). So called from the notion that it is straight, though it is not; the lower portion of the bowel before it opens outwards by the orifice called the anus.
- SEPSIS** (Gr. *sepo*, to putrefy). Putrefaction, infection with pathogenic, disease-giving, micro-organisms (very small organisms). The presence of disease-producing germs or their poisons in the blood or tissues. **ANTISEPSIS**. The destruction of germs causing disease. **ASEPSIS**. A condition in which such organisms are absent.
- STREPTOCOCCI** (Gr. *streptos*, twisted; *kokkos*, a berry). A genus of bacteria.
- TOXÆMIA** (Gr. *toxicon*, poison; *haima*, blood). Blood poisoning by bacterial toxins.
- TRAUMA** (Gr. *trauma*, a wound). A wound, a lesion.
- UTERUS** (L.). The womb, a hollow symmetrical organ situated between the bladder and the rectum and above the vagina.

# INDEX

## A

- ABERDEEN Inquiry, 100  
 Abortion, Ills arising from,  
     108, 109, 191  
 Albuminuria, 138  
 Anæsthetics, 76, 77, 78, 137,  
     172  
 Ante-natal Care, 68, 86, 90,  
     92, 93, 107, 125, 127, 135,  
     137, 140, 144, 146, 147  
 — Clinics, 87, 88, 89, 94,  
     140, 201  
 Antiseptics, 60  
 Asepsis, Ignorance of, 59, 60  
 Attention at Delivery, Table,  
     101  
 Australia, 131, 169

## B

- Bacterial Growth in Uterine  
     Cavity, 51  
 Bad Technique in Hospitals,  
     45  
 Baldwin, M.P., Rt. Hon. Stan-  
     ley, 199  
 Barrett, Lady Florence, 92  
 Beecham's Pills, 109  
 Bell, Dr. Margaret, 34  
 Berkley, Dr. Comyns, 46, 50,  
     52, 85, 108, 109  
 Bourne, Dr. Aleck W., 59, 94,  
     138  
 Breech Presentation, 74, 75  
 British College of Obstetricians  
     and Gynæcologists, 78, 121  
 British Consul in Berlin, 163  
 British Medical Association,  
     58, 78  
 British Medical Association  
     Scheme, 135

## C

- Cæsarean Section, 49  
 Campbell, Dame Janet, 28,  
     39, 43, 47, 53, 56, 84, 95,  
     100, 177  
 Canada, Care of Maternity, 174  
 Canadian Department of  
     Health, 19  
 Canadian Tuberculosis As-  
     sociation, 20  
 Care of Maternity :  
     Australia, 169  
     Canada, 174  
     Denmark, 155  
     France, 157  
     Germany, 163  
     Holland, 145  
     Irish Free State, 168  
     Latvia, 167  
     New Zealand, 171  
     Norway, 156  
     Poland, 167  
     Southern Rhodesia, 175  
     Soviet Russia, 164  
     Sweden, 150  
     United States, 175  
 Carnegie Model Child Welfare  
     Centre, 168  
 Carrier Doctors, 21, 98, 102,  
     104  
 — Midwives, 104, 144  
 Cash Maternity Bounty, 131  
 — — — in Australia, 169  
 — — — under National  
     Health Insurance, 131  
 Central Midwives Board, 59,  
     61, 67, 69, 70, 73, 74  
 Children, Circumstances of  
     Birth of, 37  
 Civic Medical Service, 89, 123

Clark, Dr. Veitch, 16, 70  
 Collins, Dr. Garland, 57, 91  
 Committee on Maternal Mor-  
 tality, 60, 78, 84, 92, 100,  
 107, 144  
 Contraceptives, 110  
 Convalescent Homes, 127  
 Cook, Dr. Frank, 108  
 Co-operative Housekeeping,  
 133  
 Cruikshank, Dr., 206

## D

Danger to Mothers, 21  
 Day Nurseries, 133  
 Death in Childbirth, Causes of,  
 Table, 205  
 ———, Rate of:  
 British Empire, 53  
 Canada, 15  
 England and Wales, 15, 204  
 Holland, 52  
 Lancashire and Yorkshire,  
 17  
 Scandinavian Countries, 52  
 Scotland, 16  
 United States of America,  
 18  
 In various Countries, Table,  
 203; in England and  
 Wales, Table, 204  
 Death in the Cotswolds, 35  
 Deem, Dr. Helen, 171  
 Delivery, Kind of attention at,  
 Table, 101  
 Denmark, 52, 155  
 Departmental Committee on  
 Maternal Mortality, 60, 78,  
 84, 92, 100, 107, 144  
 Departmental Committee on  
 Training of Midwives, 64,  
 69, 73, 75, 77, 78  
 Doctors, Carriers of Disease,  
 21, 98, 102, 104  
 Drugs in Labour, 76, 77, 78,  
 172  
 Duke Street Parish Hospital,  
 Glasgow, 44

## E

East End Mother, Letter from,  
 192  
 East London Mother, Budget  
 of, 23  
 Eclampsia, 90, 91, 138  
 Ellen of Manchester, 33

## F

Factory Strain, 112  
 Factory and Workshop Act,  
 1901, 131  
 Fairbairn, Dr. John S., 74  
*Filius nullius*, 120  
 Forceps, Irresponsible Use of,  
 49, 103  
 France, 157  
 Free Municipal Service for  
 Maternity, 97  
 Fry, Dr. R. M., 84

## G

General Medical Council, 52  
 Germany, 163  
 Gilmour, M.P., Rt. Hon. Sir  
 John, 186  
 Greenwood, M.P., Rt. Hon.  
 Arthur, 200

## H

Henderson, M.P., Rt. Hon.  
 Arthur, 184  
 Holland, 52, 58, 145  
 Holland, Dr. Eardley, 46, 49,  
 75, 77, 93  
 Home Helps, 27, 32, 78, 79, 81,  
 82, 84, 87, 130, 143  
 ——— in Sweden, 152  
 ——— in Germany, 164

## I

Illegitimate Infants, Death-  
 rate of, 115

Illness in Children, 30  
 Incorporated Midwives' Institute, 69  
 Infant Mortality, Economic Factors of, 115  
 Infant Welfare in :  
   Australia, 170  
   France, 156  
   Holland, 147  
   Irish Free State, 168  
   Norway, 157  
   Poland, 167  
   South Rhodesia, 175  
   Soviet Russia, 167  
   Sweden, 153  
   United States of America, 176

Infants, Medical Examination of, 136, 140  
 Influence of Fatigue on Bactericidal Power of Human Blood, 84  
 Inglis, Elsie, Memorial Hospital, 105  
 Inquests on Maternal Deaths, 106  
 Inquiry into Maternal Deaths, 106, 107  
 ———— in Aberdeen, 100; in Canada, 19; in U.S.A., 18, 109, 111  
 Irish Free State, 76, 168

## J

Jellett, Dr. Henry, 49, 50, 55, 59, 63, 71, 96, 106, 128  
 Jewson, Miss Dorothy, 191  
 Johnstone, Prof., 50

## K

King, Sir Truby, 171  
 Kinloch, Dr. Parlane, 45, 100, 102, 105  
 Kinloch, Parlane; Smith and Stephen, Drs., 100  
 Kjelsberg, Mrs. Betzy, 156

## L

Labour, Importance of, 93  
 Labour Party Scheme, 142  
 Latvia, 167  
 Lawrence, M.P., Miss Susan, 200  
 Liddiard, Miss Mabel, 188  
 Lock Hospital, 44  
 Lowest Maternal Mortality, 155  
 Lysol, 60  
 Lyster, Dr. Robert, 116

## M

MacDonald, M.P., Rt. Hon. James Ramsay, 184  
 McLroy, Prof. Louise, 41, 96  
 McMillan, Miss Margaret, 185  
 McMurphy, Dr. Helen, 79, 175  
 Manchester Med. Off. of Health, 37  
 Maternal Mortality Departmental Committee Scheme, 78, 144  
 Maternal Mortality, England and Wales, Table, 205  
 ———— International, Table, 204  
 ———— of Negroes, 18, 176, 177  
 ———— Poverty as cause, 18, 19  
 ———— in Textile Towns, 17  
 ———— Wages of Husband, 18  
 Maternity Benefit, Nat. Health Ins., 113, 131, 132, 135, 141, 142; delay in, 67  
 Maternity and Child Welfare Act, 1918, 79, 95, 142  
 Maternity Hospitals, 38, 45, 100, 105, 126, 134, 139, 143  
 Medical Officers of Health :  
   Birmingham, 100  
   Cardiff, 186  
   Glasgow, 17, 43

- Medical Officers of Health—  
*continued*  
 Hampshire, 116  
 Hampstead, 94, 106  
 Huddersfield, 80, 88, 96, 108  
 Manchester, 16, 37, 70  
 West Ham, 57, 91  
 Medical Practitioner, 96, 125,  
 129  
 ——— Charges against, 46,  
 47, 61, 103, 104, 107  
 ——— and Midwife, 62, 65,  
 96, 100, 139  
 Medical Students' Training in  
 Midwifery, 52, 53, 54, 144  
 ——— in Holland, 53, 146  
 ——— in Norway, 156  
 Medical Women, 141  
 Medical Women's Federation  
 Scheme, 140  
 Mellanby and Green, Drs.,  
 21  
 Midwifery Rules, 61, 67, 69,  
 73, 125, 128, 130, 172  
 Midwives' Joint Committee  
 Scheme, 141  
 Midwives' Act, 1902, 56, 59;  
 1916, 59; 1926, 57, 59;  
 Scotland, 56  
 Midwives, Bill for Drugs, 68  
 ——— Censuring of, 73  
 ——— Duties of, 69, 137, 141  
 ——— in East End, 66  
 ——— Fees paid to, 66, 69, 71,  
 72  
 ——— Poverty of, 70  
 ——— Proportion of trained, 56  
 ——— salaried, 71, 169; abroad,  
 149, 151, 155, 162  
 ——— training of:  
 England, 59, 60, 69, 71  
 Denmark, 155  
 France, 162  
 Germany, 163  
 Holland, 58, 148  
 New Zealand, 59, 171  
 Norway, 156  
 Poland, 168  
 Russia, 165  
 Sweden, 58, 151  
 Midwives, untrained, 20, 56, 59  
 ——— unqualified, 57, 58, 171  
 Model dwelling, L.C.C., 28  
 Moore, Dr. S. G., 80, 88, 89,  
 96, 108, 201  
 Mosley, M.P., Lady Cynthia,  
 190  
 Mossé, Mlle. C., 162  
 Mother *v.* Danger, 97  
 Mothers' Allowances, 133  
 ——— Lack of Care, 29, 63, 84,  
 92  
 Moullin, Col. C. Mansell, 186  
 My Little Son, a Challenge, 36  
 My Mother, Case of, 55
- N
- National Baby Week Council,  
 24  
 National Conference on Mater-  
 nity and Child Welfare, 85  
 National Health Ins. Act, 113,  
 143  
 National Maternity Service,  
 121-34  
 National Midwifery Service, 71,  
 95, 121  
 Natural Child, 115, 154, 170  
 Neglect by Medical Practi-  
 tioners, 46, 49, 51, 98  
 New York Consultants in  
 Obstetrics, Rules of, 177  
 New York State Dept. of  
 Public Health, 34, 177  
 New Zealand, 76, 171  
 ——— Royal Society for  
 Health of Women and  
 Children, 172  
 ——— State Insurance, 173  
 ——— Widows' Pensions,  
 173  
 Newman, Sir George, 16, 42,  
 86  
 Normal Labour, 64  
 Notification of Pregnancy, 88,  
 127, 202  
 Nutrition of Pregnant Woman,  
 22, 23



## O

- Obstetrics, insufficiency of  
Training, 52  
Obstetric Specialists, 97, 124  
Old Ford Road, 27, 40, 119  
Ophthalmia Neonatorum, 136,  
104  
Oxford Road, Manchester, 26

## P

- Paget, T. L., New Zealand, 44  
Panel of Obstetricians, 52  
Pelvic Measurements, 76  
Pelvis, Increased Size of, 92  
Pethick Lawrence, M.P., F. W.,  
200  
Picken, Dr. Ralph M. F., 186  
Pituitrin, Danger of, 77  
Placenta, Delivery of, 76, 172  
Plimmer, Rosedale and Ray-  
mond, Drs., 23  
Poland, 167  
Poor Mother, Letter of, 31  
Practising Midwife, Letter  
from, 194  
Pregnancy, Voluntary Noti-  
fication of, 88, 127, 202  
Pritchard, Dr. Eric, 196  
Puerperal Infection, 21, 42,  
50, 60, 84, 99, 104, 105  
— Fever, 42  
— Sepsis, Tables, 43, 205

## Q

- Queen Charlotte's Hospital,  
38  
Queen's Institute of District  
Nurses, 72

## R

- Rats, Experiments on, 23  
Rooy, Prof. van, 145  
Royal College of Physicians, 78

- Royal Free Hospital, 39, 40  
Rubber Gloves, 60  
Rude, Dr. Anna E., 176  
Russia, 110, 164

## S

- Scotland, Midwives in, 56  
Scott, Sir Samuel, 193  
Scottish Board of Health, 60,  
99  
Scraser, Mr. F. E., 94, 106  
Simmelweiss, 99  
Separate Rooms for Maternity,  
45  
Sepsis, Death by, 51  
Shaw, George Bernard, 98, 182  
Simpson, Sir Alexander Rus-  
sell, 64  
Simpson, Miss E., 188  
Snowden, M.P., Rt. Hon.  
Philip, 96  
Southern Rhodesia, 175  
Soviet Russia, 110, 164  
Still-Births, 33; Causes of, 49,  
Table, 206  
Streptococcus hæmolyticus,  
104, 105  
Suffering of Mothers, 47  
Sweden, 52, 53, 151

## T

- Toxæmia, 21, 91

## U

- Ulcers, Varicose, 28  
United States of America, 18,  
35, 109, 175  
Unmarried Mother, Suffering  
of, 119  
— — — Death-rate of, 116  
— — — and Mental Defi-  
ciency Act, 118  
— — — refused Aid, 116,  
118, 119

- Uterine Action, Danger of Inefficient, 75
- V
- Vienna Maternity Hospital, 98  
 Vitamine A, 22  
 Vitamine B, 23
- W
- Wage-earning Mothers, 111, 132  
 Washington Draft Maternity Convention, 112  
 Watson, Sir Alfred, 113
- Whitehouse, Prof. Beckwith, 51, 74, 91  
 Wilkinson, M.P., Miss Ellen, 189  
 Woman Doctor, Outlook of, 32  
 Women's Hospital, Amsterdam, 40  
 Woodbury, Dr. Robert Morse, 18, 111  
 Woolf, Miss Lilian, 119  
 Working-class Mother, Letter from, 191
- Y
- Young English Doctor, Difficulties of, 54