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MATERNAL MORTALITY

EXTRACT

FROM

CHAPTER IX

OF

Final Report of Departmental Committee on Maternal Mortality and Morbidity

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Chapter IX

CONCLUSIONS AND RECOMMENDATIONS

The Committee after investigation of 5,800 deaths in childbirth point out that the causes of death are varied "clinical errors being contributed to by economic conditions". They are, however, "convinced that the primary essential for the reduction of a high maternal mortality is sound midwifery, before, during, and after childbirth, and this does not chiefly depend upon administrative arrangements or the expenditure of public money."

It is not suggested that *all* maternal deaths are preventable; the gradual raising of the "standard of health and physical development of women" and " great advances in medical knowledge" must be made.

"Nevertheless, we are confirmed in the opinion expressed in our Interim Report that at least half the deaths which have come under review could have been prevented had due forethought been exercised by the expectant mother and her attendant, a reasonable degree of skill been brought to bear upon the management of the case, and adequate facilities for treatment been provided and utilised."

The first group of Conclusions is *Clinical* and deals with "Management of Pregnancy and Labour," p. 135.

This section will be studied by all who have expert knowledge.

The matter which will appeal to all our Correspondents is the Section on "II. Administrative. Imperfection of Maternity Service," which is given below in full :—

1. *Training of Students.*

There is a serious lack of facilities. This is partly owing to the training of pupil midwives who will not eventually practise, and also to the fact that no satisfactory arrangements have yet been worked out between teaching hospitals and neighbouring Local Authorities to make beds in municipal hospitals available for teaching purposes.

2. *Facilities for Post-Graduate Instruction.*

Post-graduate facilities for doctors are inadequate. It is most difficult for older practitioners to obtain practical instruction in modern ante-natal work, even if they so desire.

3. *Encouragement of Specialisation.*

Little encouragement is given to young obstetricians and gynaecologists to establish themselves in the non-teaching provincial centres. The gynaecology in such places is often in the hands of general surgeons without special interest or experience in obstetrics, and the hospitals lack a gynaecological department. In these circumstances an obstetrician may find it impossible to develop his practice in the speciality to which he has devoted particular study, time, and attention.

4. *Midwives.*

The Committee have been much impressed by the need for better instruction of midwives in ante-natal care and nursing methods. There is dissipation of effort among different training centres, which are too numerous and vary widely in efficiency. There is great need for "refresher" courses. Except in certain rural areas there is at present no organised service of midwives, with adequate status and traditions of its own. The independent midwife is often harassed by financial anxiety, and the absence of security is discouraging.

5. *Untrained Handywomen* are unfortunately still extensively employed as maternity nurses.

6. *Ante-Natal Supervision.*

There is too little ante-natal supervision by general practitioners and midwives, and what there is is often too perfunctory to deserve the name. Ante-natal clinics are too often conducted by those who are not practical obstetricians, and there is lack of co-ordination between them and those conducting the deliveries. An ante-natal clinic unconnected with a hospital is often seriously hampered by being unable readily to obtain in-patient treatment for abnormalities that may be discovered at the clinic. At many clinics the discovery of an abnormality involves delegating responsibility; this may lead to regrettable and dangerous delay, and there is in some cases no effective organisation for ensuring the continuance of obstetric supervision and treatment.

7. *Hospital Accommodation.*

There is urgent need for more beds for ante-natal abnormalities, including inter-current disease, and for the admission of cases of sepsis at an early stage. Maternity hospitals often suffer from a lack of responsible medical control and co-ordination, and difficult cases are too often dealt with by an inexperienced junior resident.

The Summary of Recommendations is also given in full :—

B. Summary of Recommendations.

1. *Sepsis (Puerperal Infection).*

Suggestions as to the necessary antiseptic toilet have been put forward on pages 112 to 114. The use of rubber gloves in the conduct of labour is advocated for the reasons given on page 115. In view of the accumulating evidence of the danger of droplet infection from the mouth and nose of attendants and others, the use of adequate masks is strongly advised. Sufficient beds should be available for difficult obstetrical cases and for the early admission of cases with puerperal infection.

2. *Toxaemias.*

There should be a more effective examination of urine and estimation of blood pressure during pregnancy, and in order to carry this out it is advisable that midwives should be trained to make blood pressure determinations. More beds should be provided for the treatment of toxaemias in their early stages, and the importance of early and adequate treatment of these conditions should be much more fully realised.

3. *Haemorrhage.*

If a case of "warning haemorrhage" occurs, the patient should be placed without delay in a suitable institution. The doctor's midwifery equipment should include apparatus for intra-venous injection. Blood transfusion services should be more generally organised.

4. *Pre-Existing Disease.*

Every pregnant woman should have a routine medical examination by a doctor during the early months of pregnancy. More hospital accommodation should be provided for the treatment of

cases of heart disease, tuberculosis, and nephritis associated with pregnancy. Where it appears that further childbirth will endanger life, medical advice should be given as to the prevention of pregnancy. More vigorous efforts should be made to apply effectively and widely the new knowledge now available for the prevention of rickets.

5. *Maternity Services.*

(a) Training of medical students. Recommendations as to the education of the student in obstetrics have been put forward in the Interim Report. The Committee wish to impress on teaching hospitals and Local Authorities the need for their co-operation in the provision of facilities for the instruction of students in obstetrics. In order to avoid the present serious "wastage" of cases in the instruction of pupil-midwives who will not ultimately practise midwifery or take posts as health visitors, the C.M.B. certificate should not be made a requisite for appointments in which midwifery experience is not essential.

(b) Facilities for post-graduate instruction. The Committee recommend that steps should be taken to provide increased opportunity, either at special post-graduate hospitals or elsewhere, whereby doctors already in practice may be enabled easily to obtain further practical instruction in ante-natal care and in obstetrics.

(c) Training and employment of midwives. The Committee recognise that another official Committee has dealt with this problem, and with their recommendations they are in general agreement. They consider that some means should be found for providing post-certificate experience before registration as a practising midwife. "Refresher" courses should be provided for midwives already in practice, and special efforts made to encourage their attendance.

The Committee consider that a handywoman should never be employed as a maternity nurse and that a trained midwife should always be available to carry out maternity nursing in cases attended by a doctor or a medical student working under a doctor's direction.

(d) Ante-natal supervision. The care of the patient during pregnancy should, whenever possible, be undertaken by the person who will be responsible for the delivery. There is great need for more general staffing of ante-natal clinics by medical officers who are closely in touch with the actual practice of midwifery, whether they be obstetric specialists or general practitioners. Furthermore, ante-natal clinics should, whenever possible,

have an intimate working connection with a hospital where maternity beds are available. Measures should be taken to educate the public as to the need for ante-natal care, and as to what it may be expected to accomplish when efficiently carried out.

(e) Maternity hospitals. With reference to maternity hospitals, the Committee desire to make the following recommendations :—

(i) that cases of puerperal sepsis, whether arising in hospital or admitted from outside, should not be treated on the premises of a maternity hospital, unless an entirely separate block, separate nursing and ward staff and separate staff accommodation are provided;

(ii) that for emergency or other cases which may be a source of danger on account of potential sepsis, special provision (separate small wards and labour wards, with special allocation of staff) should be made;

(iii) that cases of abortion should not be admitted to ordinary maternity wards;

(iv) that in the interests of economy, as well as to facilitate specialist treatment of non-obstetric conditions associated with pregnancy and childbirth, new maternity accommodation should, where practicable, be associated with general hospitals;

(v) that very large maternity units are disadvantageous in that the essential personal supervision, both medical and administrative, is difficult to maintain;

(vi) that the method of medical staffing of maternity hospitals so as to secure prompt specialist service for serious cases calls for reconsideration as indicated in the Report.

6. *Development and Co-ordination of Existing Maternity Services.*

The essential services considered by the Committee necessary to secure a higher standard of care for the mother during pregnancy, labour and the puerperium were formulated by the Committee in the Interim Report and may be briefly recapitulated here :—

(i) The provision in every case of the services of a registered midwife to act either as midwife or as maternity nurse (the midwife being responsible for normal midwifery and for routine ante-natal supervision).

(ii) The provision of a doctor to carry out ante-natal and post-natal examination in every case, and to attend as may prove necessary during pregnancy, labour and the puerperium all cases showing any abnormality.

(iii) The provision of a consultant, when desired by the attending doctor, during pregnancy, labour and puerperium.

(iv) The provision of certain ancillary services, dentistry, home helps, sterilised outfits and facilities for pathological investigation as desired by the doctor.

7. *Encouragement of Specialisation.*

The Committee consider it important, in order that expert obstetric advice and assistance may be readily available in every part of the country, that gynaecological departments should be established, when they do not already exist, in all the larger non-teaching provincial hospitals, and that such departments should be staffed not by general surgeons but by obstetricians.

8. *Inquiries into Maternal Deaths.*

The Committee desire to see confidential inquiries into the circumstances of maternal deaths continued by the Public Health Authorities, but deprecates the institution of a system of inquiry by a Coroner into every maternal death as a matter of routine.