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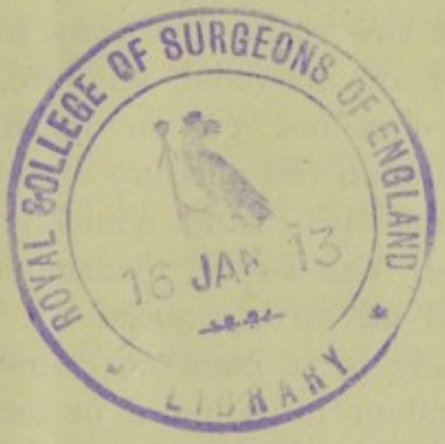

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Dr. A. Martin, of Berlin, in an article on medico-social questions in England, speaks as follows concerning the teaching of midwifery in the English medical schools :—

"The arrangements of the medical schools in England for midwifery education are very imperfect. If we look away from the long-renowned lying-in hospital, the Dublin Rotunda, and the very limited similar opportunities in Edinburgh and Glasgow, we find that the medical student has nothing analogous to our midwifery clinics. The student is taught midwifery theoretically. He learns practice among the out-patients. To these the professor of midwifery hardly ever goes. In London, for instance, these professors live in the far west, miles away from their hospitals, and from the midwifery out-patient departments attached to them. The teaching of the students in midwifery is almost exclusively in the hands of young assistants, who have been qualified one or at most two years, live away from the places in which the patients are delivered, and are, or should be, called if the labour does not go on naturally. It depends, therefore, entirely upon the pleasure of these young assistants whether the student is or is not clinically instructed in the mechanism of labour, the aseptic management of childbirth and child-bed, and all further questions. It is to be considered also that there is at hand no trained midwife or monthly nurse. The student must more or less instruct himself. It says much for the value of the theoretical teaching that these young men do not have more disastrous experiences than in fact actually happen."

In this paragraph Dr. Martin correctly represents how midwifery is taught in England. Suppose medicine and surgery taught in like manner! Conceive that the teachers of medicine and surgery gave lectures, but never went into

the wards. That the patients were left to students, who made the diagnoses, treated the patients, and if in doubt, or if a patient did not seem to be going on well, called in the house physician or house surgeon; that he did anything that to his judgment seemed good, and only in very serious difficulty or danger called in one of the eminent men on the visiting staff of the hospital.

It may be said, "Oh, but childbirth is a natural process, and skilled interference is only occasionally called for; childbirth is not at all analogous to the diseases treated in medical and surgical wards."

But the cure of disease is also a natural process. The healing of wounds, the uniting of fractures, the elimination of poisons, the combat of leucocytes with micro-organisms, the recovery of function after brain tissue has been damaged, are all natural processes, in which the aim of treatment is to put the patient under favourable conditions and then leave Nature to do her work.

The fancy picture I have drawn of the management of medical and surgical wards on the same lines as out-patient maternity departments, is an absurdity and impossibility not so much because the visits of the higher officers would be too few, as because they would come too late. The highest medical and surgical skill would be called in when the patient was dying, or had been irreparably damaged by erroneous treatment. The same amount of attention given in time might have secured recovery. When the surgeon has properly put up a fracture, the patient would be safe in the hands of instructed dressers, even though the surgeon should not see him again. If the physician has made his diagnosis and laid down the principles of treatment, very moderate skill is enough to manage the details.

Midwifery, rightly understood, is a branch of preventive medicine. The birth of a child is a process which nature will always complete, and after which women always recover, unless hindered by obstruction or disease. The business of a skilful accoucheur is to find out the conditions which, if allowed to persist, will cause obstruction, and to prevent the patient getting into the condition known as "obstructed

labour." Obstructed labour means either that the medical attendant is incompetent, or that he has been prevented from doing what ought to have been done.

Obstructed labour is caused by the child being too large, or the pelvis too small, or the child in a wrong position. If the patient is seen at the beginning of labour only by a person who knows not how to find out the size and position of the child and the size and shape of the pelvis, he will let labour go on until the grave condition of the mother makes interference both difficult and dangerous. But if the patient is seen early by a competent person, a wrong position of the child can easily be put right. If the pelvis is big enough to let a child pass at all, its delivery, if undertaken at the proper time, is not more dangerous than natural delivery. When the pelvis is so contracted that the child cannot be delivered through the natural passage at all, Cæsarean section done at the proper time is now attended only with a small mortality; but if postponed until the patient is exhausted by protracted labour, death is more likely to be the result than recovery.

The mortality from the diseases affecting pregnant and puerperal women likewise depends upon whether treatment is timely or too late. There are certain of these diseases, it must be admitted, which we know not yet how to prevent, such as eclampsia, rupture of the uterus in easy labour, pulmonary embolism. But most are under our control. The mortality of placenta prævia has varied in different places from 5 to 40 per cent.; and the smallest mortality cannot be reached without early treatment. The aseptic precautions upon which the prevention of puerperal fever depends must be taken throughout the labour. It is of no benefit to the patient that an operator has taken pains to sterilise his instruments if someone else's dirty fingers have already lodged septic germs in the vagina.

Good midwifery teaching is that which teaches the student how to *prevent* complications in labour and disease afterwards.

The present system is unfair to the patients. They are seen, at the time when skilful treatment is most wanted, only by a student, not quite ignorant, but quite inexperienced and

untrained in the practice of midwifery. If aid is needed, it is not sent for till this gentleman's unpractised eyes and hands have found out that something is wrong. It is disadvantageous to the student, for he does not learn clinically what ought to be done, but only what can be done under unfavourable conditions allowed to come about by his inexperience.

It is true that students are not allowed to attend cases of labour until they have in some way satisfied the head of the department that, from books or lectures, they have gained some elementary knowledge of midwifery; true, also, that the student going to his first case is generally accompanied by a more experienced man. These precautions lessen but do not remove the evil results of the system.

The General Medical Council has had before it a recommendation to the effect that each medical student must, before presenting himself for the final examination, have attended at least six cases of labour under the personal supervision of a qualified practitioner. If the Council makes this recommendation a rule the present mode of teaching practical midwifery must be altered; and it is time it was.

Should the Medical Council make this recommendation a rule it will have to define what "personal supervision" means. The six cases may be attended under the supervision either (1) of a general practitioner or (2) of a hospital officer. If (1) the former should come to be the rule, the hospitals must cease to profess to teach practical midwifery. But if (2) the hospitals are to do it, the question comes, How? Will the Medical Council allow a class of students to be taken to watch a case of labour, to have the important points demonstrated to them, and accept presence at such a class as attending a labour "under personal supervision"? Supposing this method should find favour, it is obvious that the larger the class, the less the practical instruction which each member of it can get: and therefore the maximum number of students who may form such a class must be defined. Assuming this to be done, another question arises—viz. to what extent will the governors of hospitals demand that their midwifery teachers shall consider the wishes of their patients? I do not see how it is possible for more than one, or at most, two

students to be practically taught from one patient, and I think that if two students, beside the supervising practitioner, were present, and were really practically instructed, the patient would resent it. If the qualified practitioner is to thoroughly teach the student practically, and yet pay due regard to the patient's feelings, I think he must have one student, and one only.

A further question will arise, which is, What amount of attendance does this "personal supervision" mean? Is the qualified practitioner to remain in attendance from beginning to end, just as he would if the woman were a private patient whom he had engaged to attend; or will it be thought enough if he looks in occasionally to see that the patient is going on well and the student is at his post? The Medical Council will have to define this.

How should the London student be taught practical midwifery?

The ideal way is that midwifery should be taught in lying-in hospitals in the same way as medicine and surgery are taught in general hospitals—where the teacher demonstrates in the wards what he has talked about in his lectures. But only one of the lying-in hospitals of London is open to medical students; and while this is the case the bulk of the London students must continue to learn practical midwifery at the homes of the patients. How, then, can midwifery teaching at the patients' homes be made effective?

At most hospitals there is a resident qualified practitioner who undertakes the supervision, in the absence of the visiting staff, both of the obstetric wards and the maternity department. It will be impossible for this officer personally to supervise the attendance of each student on six labours. Suppose that an annual average of only fifty students enters; this will mean that each year 300 labours must be attended by a qualified officer of the hospital; and an officer doing this amount of midwifery work could do nothing else.

I have urged above that the most important thing in midwifery practice is *early diagnosis*, in order that complications may be *prevented*. The patient should be instructed to send without delay when she thinks labour has begun.

The qualified practitioner should go at once with the student. He should first direct the student in seeing that all aseptic measures have been taken, and that antiseptics are ready. Then he should ascertain by abdominal palpation and measurement the size and position of the child, the degree to which the child's head, if presenting, is engaged in the pelvis, and the ease with which it can be further pressed down into the pelvis. Then he should observe the condition of the genital soft parts, and then the size and shape of the pelvis. He should next investigate the general condition of the mother, and watch one or two pains to judge of their frequency and strength. The student should do all these things himself, the qualified practitioner instructing him, and confirming or correcting the student's observations.

Let us assume that everything has been found to be natural. What has now to be done? Only to let the patient alone until the child is born; then to tie the cord and assist the third stage of labour. The latter two duties are, if the labour has been natural, very easy.

Suppose on the other hand that a complication is present. The qualified practitioner should do what at once is necessary; or if the time has not come for interference, he should direct the student how to find out when the time for giving help is at hand.

In short, that which is both most important and most difficult to teach in midwifery is diagnosis early in labour. This alone can make the practice of midwifery a scientific pursuit. If the student understands the mechanism of labour, and the special features of the particular case he is watching, the observation of its course becomes interesting; if he does not, it is drudgery.

If the recommendation is made a rule, each student will have to attend twenty cases, of which six must be under the supervision of a competent teacher; that is to say, in the hospital maternity charity six patients out of every twenty will have the benefit of the skill of a carefully-chosen accoucheur. Six-tenths will have to put up with an inexperienced student. How is it to be decided which patients are to have the better attendance, which the

worse? The hospital governors may have something to say on this point. I think that all the patients should have the best possible attendance.

I suggest that an officer (or officers, according to the number of patients and of students) should superintend the outdoor maternity charity, and teach midwifery practically to students. He should give his whole time to this work, and should receive sufficient direct remuneration to make the post attract a capable man. This officer should go to each case with the student appointed to attend it. He should let the student perform every manipulation, showing him how to do it, and then should correct or confirm the result of the student's investigation. The observations made should be recorded and preserved.

Roughly speaking, in about three-fourths of the cases natural delivery may be confidently expected. If so, the superintending officer should leave the student in charge. If he be fit to attend labour cases, he may be trusted to tie the cord and express the placenta from the vagina.

If, on the other hand, the superintending officer finds that an abnormal condition is present, he should take the case under his own charge and treat it in the proper way.

The provision of an officer with such duties would secure the safety of the patients and the proper instruction of the students in practical midwifery. Such a system would not require of the superintending officer the waste of time in watching a natural process which is the most irksome part of midwifery practice.

Such a system would recognise the essential fact of good midwifery practice, which is, that prevention is better than cure. It would give the patients proper attendance. I am sure that some such change would be welcomed by none more heartily than by the students. An intelligent student does not enjoy being left by the bedside of a patient, comforted against dread of disaster only by the knowledge that most cases of labour would end happily if no doctor were there at all.