Maternal mortality in childbirth : ante-natal clinics: their conduct and scope.

FOR OFFICIAL USE.

Memorandum 145/M.C.W.

MINISTRY OF HEALTH.

MATERNAL MORTALITY
IN
CHILDBIRTH.

Ante-Natal Clinics: Their Conduct and Scope.

LONDON:
PUBLISHED BY HIS MAJESTY'S STATIONERY OFFICE.
To be purchased directly from H.M. STATIONERY OFFICE at the following addresses:
Adastral House, Kingsway, London, W.C.2; 120, George Street, Edinburgh;
York Street, Manchester; 1, St. Andrew's Crescent, Cardiff;
15, Donegall Square West, Belfast;
or through any bookseller.
1929.
Price 1*d. Net.*

32—9999.

Ante-Natal Clinics: Their Conduct and Scope.

I. *Introductory Considerations.*

It is acknowledged that, speaking generally, the present standard of ante-natal care remains below what is required for safeguarding the mother, even within the limits of our present knowledge. Some pregnant women receive no ante-natal supervision at all, and there is reason to believe that in other cases the supervision is so insufficient that harm may be done by giving a false sense of security.

It is important to obtain for every pregnant woman a high standard of examination and treatment, and it appears certain that a definite standard for such work would be helpful to those responsible for organising and administering ante-natal clinics, as a further step in the reduction of the present high mortality rate. The adequacy of such clinics necessarily affects the whole of the work done for the pregnant woman, not only at the present time, but in the future, since a proportion at least of these clinics are attended by medical students and pupil midwives, and the educational effects are thus far reaching.

II. *Principles of ante-natal care.*

1. Every pregnant woman should receive sufficient ante-natal care to ensure that a difficult labour will be foreseen as far as this can be done by efficient examination. Such examination should include not only the pelvic and abdominal organs, but the general physical condition: the home conditions of the patient should be investigated as well.

2. Every woman should receive sufficient ante-natal supervision to ensure the early detection and treatment of toxaemia within the limits of our present knowledge.

3. Ante-natal care should include measures directed against infection (e.g., dental care, the treatment of infection of the cervix), and measures increasing the resistance to infection, as well as directions as to preparations for labour and the puerperium.

4. Measures should be taken to include within the scope of ante-natal care the diagnosis and treatment of venereal diseases.

5. The closest co-operation should be maintained between the clinic and all persons in whose charge the pregnant woman may be during pregnancy, labour and the puerperium.

6. In order that the high standard of ante-natal care which is necessary may be maintained by midwife and doctor, the educational effect of a well-organised clinic must be always kept in mind.

III. *Application of principles.*

Details of the application of these principles are given below, and it must be realised that any restriction in the extent of the ante-natal care here described will diminish that degree of safety to the woman in childbirth which is possible in the present state of our knowledge. It is obvious that such intensive care can only be given when the patient actively co-operates with the clinic or doctor. Such co-operation can be facilitated by educational propaganda, and by the following up of cases to ensure regular attendance. A proportion of the necessary observations might well be made in the patient's home by the midwife, in co-operation with the clinic or practitioner.

2866. Wt. —— 6,500. 7/29. Wy. & S., Ltd. Gp. 2.

IV. *The Ante-Natal Clinic.*

Ante-natal clinics may belong to two categories, namely, (*a*) The Consulting Clinic, (*b*) The Clinic for routine Examination. The Consulting Clinic may serve both purposes, but there is always likely to be a large number of municipal clinics whose function will not be consultative. It is possible that under a reformed Maternity Service much of the work of such routine examination clinics may be transferred to the family practitioner and the trained efficient midwife, but at present they are essential for securing ante-natal care where it would not otherwise be available.

The Consulting Clinic will necessarily be staffed by obstetricians of standing, since it could not otherwise adequately perform its functions, and it may therefore be assumed that the organisation, equipment, etc., will be sufficient for its purpose.

The Examination Clinic.—This is the type of clinic under consideration, and will be referred to subsequently simply as the "Ante-Natal Clinic."

V. *The Organisation of an Ante-Natal Clinic.*

1. *Premises and Equipment.*

The success of a clinic will depend to a considerable extent on suitable premises being secured either in an existing institution or elsewhere; the essentials of warmth, cleanliness and privacy, are, however, comparatively easily obtained. The lack of a special building should not discourage organisers. An important consideration is the question of accessibility. The essential furniture and equipment is simple and inexpensive.

2. *The "Personnel."*

(a) *The Medical Officer.*—The Medical Officer, whether whole or part time, should be trained and experienced both in obstetrics and ante-natal work, and should preferably have held a resident appointment in a Maternity Hospital, with experience at its ante-natal clinic. Failing this at least three months' post-graduate instruction at a recognised school should be required if the Medical Officer has had no recent obstetrical experience. Obstetrical experience in general practice is extremely valuable, but should be supplemented by post-graduate training or experience in ante-natal work.

(*b*) *The Nurse.*—The Medical Officer will require the assistance of a midwife with post-certificate experience in obstetrics and ante-natal work. A second assistant will be required in large clinics for clerical and educational work.

3. *The Patients.*

The Patients will include:—

(1) Those sent by Medical Practitioners.
(2) Midwives' cases.
(3) Those coming independently.
(4) Those sent by Health Visitors.

(*a*) A patient coming under categories (3) and (4) should be asked what arrangements she has made for her confinement, and if she has not already made any should be advised to do so without delay. Under a following-up scheme it would be possible to ascertain that she does so. If she engages a midwife her ante-natal care would be secured as suggested under the next heading.

(*b*) *Midwives' cases.*—Midwives are obliged under the Central Midwives Board rules to undertake the ante-natal care of their cases, and to keep records, but many of them are unable to do so efficiently, and in assisting and educating them to do so the clinic will find great scope for useful work. If the clinic examinations are made independently of the midwife a double series of examinations is entailed, which is not only worrying to the patient, but leads to the confusion of a double responsibility. Midwives should therefore be encouraged to

bring their patients to the clinic and to do their ante-natal work there under supervision, until their knowledge of what is required and their skill in detecting abnormalities are sufficient to enable them to do the routine work in ordinary cases by themselves.

Recently trained midwives may be found able to do this work in all their cases, but even they should be urged to send their cases to a doctor or a clinic for ante-natal examination at least twice during pregnancy.

On booking a case the midwife should ascertain the name of the doctor the patient would wish to employ in case of need during labour, and should inform him of this possibility, and of the ante-natal condition. Forms might suitably be supplied for the purpose by the Local Authority. After the labour the midwife should be advised to supply the clinic with a report as to the character of the labour, and the Local Authority might pay a small fee for such reports.

(*c*) *Doctors' cases.*—If a patient attends a clinic, having already booked a doctor for the confinement, no examination should be made until the doctor has been informed of the patient's wish to attend, and his consent has been obtained. Subsequently reports should be sent to him in every abnormal case, and he in return should be asked to describe the character of the labour.

Any doctor wishing to transfer the whole or part of the ante-natal care of a patient to a clinic should be able to do so. Reports would be sent as before.

4. *Records.*

It is of the greatest importance that records of all ante-natal work should be kept and should be available to any of the trained persons who may from time to time be in charge of an expectant mother. With the patient's consent a written report should be given or sent by the Medical Officer to the doctor or midwife concerned after the preliminary examination has been made, after the special visits, and in all cases of abnormality, whether these are sent by the midwife or doctor or occur in patients already under the care of the clinic. A report of the childbirth should in return be sent to the clinic not only for use in future pregnancies, but also in order that the Medical Officer may check his findings with the actual result.

5. *Co-operation with Hospitals.*

It is hoped that Hospitals, both large and small, will be prepared to reserve beds for maternity cases referred to them by clinics or doctors, and that all clinics will work in direct association with one or more hospitals.

As Hospitals may find difficulty in providing the ante-natal care for patients living at a distance, it should be possible for them to make arrangements for such patients to attend the nearest clinic during the whole or part of pregnancy as circumstances suggest. In such cases mutual reports would be exchanged.

In all cases presenting difficulty in diagnosis ante-natal consultations with an obstetrician should be possible, either through a clinic or through the patient's own doctor.

6. *Appointments and following up.*

At the first visit to the clinic the woman should be given an appointment card and the date of her next visit booked. If she does not come on that date a note should be sent making another appointment, and if this also fails the Health Visitor should make a visit to the house. If attendance is not then secured the midwife should be informed of the fact and of her responsibility as to ante-natal care.

7. *Subsidiary Activities.*

The supply of sterilised maternity outfits for labour at cheap rates might properly be undertaken, also the supply at wholesale prices of suitable antiseptics to midwives, etc.

In necessitous cases the provision of food and milk may be desirable.

VI. *Minimum scope of ante-natal examinations.*

A patient should attend first at the 16th week of pregnancy, unless owing to trouble at a previous confinement she has been asked to attend earlier. At this visit a full medical and obstetrical history should be taken and, if she is prepared, a physical examination should be made. This should include examination of the urine, and an estimation of the blood pressure as a standard for future reference. Dental treatment, if found necessary on examination, should be arranged for. The pelvic measurements should be taken. The question of vaginal examination should be left to the discretion of the Medical Officer, but would always be desirable where there is a discharge or a history of difficult or septic labours. Wasserman reaction should be ascertained where necessary. The breasts should be examined in all cases.

After the examination by the Medical Officer is completed the nurse should enquire into home conditions, give the patient an "Advice Leaflet," and advise her on hygienic matters. Where necessary the home should be visited. The date and hour of the next visit to the clinic should be arranged.

From this time routine examinations should take place either at the clinic or the patient's home as follows:—At the 24th and 28th weeks, from then every fortnight until the 36th week, and thence weekly until she is confined. The uterine height and girth should be taken, the fœtal heart listened for, the urine tested, and general enquiries should be made, with special regard to the action of the excretory organs. The midwife should be able to do this examination in most cases at the patient's home, but *any abnormality*, however slight, *must* be brought to the notice of the Medical Officer of the clinic.

In place of, or supplementing, the routine examinations, special examination should be made by the Medical Officer at the 32nd and 36th weeks. These will be directed mainly to ascertaining the presentation of the fœtus, and the relation of head to pelvis.

It is advisable that where possible the blood pressure should be examined weekly during the last month, as a rise of pressure may be the first sign of a commencing toxaemia.

It is important that the expected date of confinement should be ascertained early in pregnancy, and be confirmed from time to time, and any patient going beyond the 40th week should be referred to the Medical Officer.

If a patient should at any time develop abnormalities rendering her case unsuitable for attendance by a midwife alone, the latter should be informed.

Generally speaking, treatment of abnormal conditions is not the work of an ante-natal clinic. Any cases requiring treatment beyond simple measures should be referred, whenever possible, to the family doctor, or to a consulting clinic, or a hospital.

Finally, the importance of co-operation between the clinic and the professional attendant, as well as the accurate keeping of records, cannot be over-estimated.

SUGGESTIONS FOR EQUIPMENT OF AN ANTE-NATAL CLINIC.

Furniture.

Doctor's Room.

Writing table; chair; patient's chair; examining couch (6 ft. by 2 ft. by 2 ft. 6 ins. high); surgical trolley (16 ins. by 16 ins. by 30 ins.) or enamelled table (for instruments, bowls of disinfectant, etc.); wash hand basin on enamelled stand (where fixture is not available); *cupboard (metal frame, glass front and sides) (instruments); *wall thermometer; fireguard.

Nurses' Room.

Writing table (small); chair; patient's chair; cupboard; wash hand basin on stand (if no fixture); small side table (for sterilizing, urine testing, etc.); *weighing machine; 2nd couch (in large clinics); fireguard; mirror.

Waiting Room.

Chairs; screens (to arrange undressing cubicles); demonstration table (for showing clothing, confinement sets, etc.); blackboard (for health talks); filing cabinet; writing table (small); chair; fireguard; mirror.

Linen, etc.

Nurses' overalls and doctor's gowns (3 of each); dressing gowns (cotton), 12; hand towels, 12; blankets, 2; mackintosh; sheets, 3; pillows, 1; dusters, etc.

Instruments, etc.

Blood pressure apparatus; urine testing apparatus, with litmus and filter papers; pelvimeter; speculum; other instruments (dressing forceps, scissors, etc., tongue depressor and torch, etc.).

Other Equipment.

Chambers; urine glasses, test tubes and stand, etc.; pail, etc.; swab jar, 4 ins. by 4 ins.; kidney trays; bowls; gloves; steriliser; nailbrushes and soap; thermometers; lysol, vaseline, etc.; catheters; inspection light.

* Non-essentials.