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TRAGEDY OF MATERNAL MORTALITY

Australia's High Figures

DOCTORS SEEK SOLUTION

Now that the Federal Government has directly interested itself in the problem of maternal mortality, and the question is being widely discussed in political as well as scientific circles, everyone will be interested in this article, the first of a series of three specially written for "The Advertiser."

By

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At the instance of the Chief Secretary (Mr. Ritchie), a conference attended by the president of the Central Board of Health, and medical experts in close touch with maternal welfare, was held recently, and this has raised hopes in the minds of the medical profession and others interested, that the tragedy of our high maternal mortality is really going to receive attention which is long overdue.

It has long been stressed that, in Australia, one out of every 200 mothers dies in childbirth every year, that the mortality is rising rather than falling, and that it is higher in Australia than in England, where there are greater slums and poverty. Although a large number of these deaths are preventable, no concerted and sustained public action has been taken. A great deal of publicity has been given to the 12 or 13 deaths from tetanus in South Australia in each of the past two years, but few—apart from the bereaved husbands and children — seem to worry over the fact that in the past 30 years never less than 40 women, and sometimes more than 70, have died in childbirth in this State each year. Unlike motor accidents and those injuries which cause tetanus, childbirth is a physiological process—it can be foreseen some months ahead; its danger can be guarded against. Childbirth is as much a moral hazard of woman as his daily work is an industrial hazard of man. But no comparison can be made between the political and administrative concern that is shown for women in childbirth and that shown for workers in factories. Two months ago there was a fascinating lecture on the blowfly problem in sheep, in which a doctor of science narrated the patient and painstaking researches by himself and his staff for four years past to ascertain the real facts underlying the problem. It would be futile—because of the ridicule it would excite—to suggest that the Council for Scientific and Industrial Research should set a doctor of medicine on a similar detailed and prolonged investigation on the practical difficulties attendant on the solution of the problem of maternal mortality. Yet fleeces are not more valuable than women.

Long Silence Broken

When the Prime Minister (Mr. Lyons) just before the last Federal election, broke the long silence on maternal mortality, disillusioned sceptics thought it was only an electioneering cry. Yet he has persisted, and at the meeting of the Federal Health Council, to be held in Canberra next March, a day will be set apart for discussion of the matter. The recent action of Mr. Ritchie will ensure that the principal medical officer of this State will attend the conference with all the facts concerning South Australia at his disposal. And that is valuable; for, by a curious anomaly, neither the Central Board of Health nor any other State Government department, has any direct relation with maternal hygiene—except in regard to puerperal sepsis. This article, therefore, is not written in any spirit of adverse criticism, but rather to applaud the Government for the step it is taking to make the coming discussion at Canberra productive of practical result.

The situation in Australia needs to be emphasised. In 1926 the Commonwealth Royal Commission on Health made four specific recommendations regarding maternal hygiene. The same year these were discussed at a conference of Ministers of Health of the Commonwealth and States of Australia and, for necessary action, were referred to the newly-created Federal Health Council. At various times since then, resolutions have been passed by that council, and in 1930 a report of Dame Janet Campbell was considered, and these resolutions were re-affirmed. Sporadic attempts to improve the situation have been made in different States, but there has been no concerted action towards evolving any national scheme. Yet surely protection of motherhood is a national question. No improvement will result simply from passing resolutions. The problem must be seriously tackled by experts, backed by public sentiment and the public purse—a declaration of war followed by the mobilisation, and maintenance in the field, of all available forces.

Australian Investigation

The facts for Australia are well attested and well known. They were investigated and published in a prize essay on the subject in 1923 by Dr. E. S. Morris, of the New South Wales Department of Health. Maternal hygiene was a special term of reference to the Commonwealth Royal Commission of Health, which published its report and recommendations in 1926. Dr. Marshall Allen, appointed Director of Obstetric Research in the University of Melbourne in the same year, later published the report of his researches. At the request of the Commonwealth Government, Dame Janet Campbell, senior medical officer for maternity and child welfare in the British Ministry of Health, toured Australia in 1929, investigating conditions; and her report was widely distributed throughout the States. All these reports agreed on the facts and the main principles of prevention.

Dr. Morris stated that approximately one-sixth of the total deaths of married women resulted from what "ought to be the normal physiological process of childbirth." For Australia as a whole the number of maternal deaths per 1,000 births was more than five in the majority of years from 1910 to 1930. Roughly speaking, one-third of these deaths occur from sepsis, one-third from the toxaemias of pregnancy, and one-third from other accidents of childbirth. In addition, numerous cases occur of illness and subsequent morbidity and invalidity, which are the result of non-fatal sepsis and of accidents of childbirth, regarding which no figures are available.

Each report emphasised the need for prenatal care of the expectant mother, for the provision of more prenatal clinics and maternity hospitals, for better training of medical students and midwifery nurses, and for closer correlation between Commonwealth and State administrations. Consequently, Sir James Barritt, with a certain amount of justice, recently criticised the Prime Minister's suggestion for a Commission, and insisted that, by these investigations, we are already in possession of the facts. But when he went on to say that what we need rather is "administration" he was on less sure ground, as further criticism has shown. The truth is that the more the problem is studied, the more it is seen that there is no single panacea, that no expert can at present visualise the perfect plan of campaign. And experience in the past 10 years has shown the fallacy of hasty judgment concerning the results of any line of attack.

Position In England

In England, when a Ministry of Health was created at the end of the war, a department of maternity and child welfare was set up, and it has worked energetically at the problem. Most valuable information is given in a report on the Protection of Motherhood by Dame Janet Campbell in 1927, and by a later report of the Departmental Committee on Maternal Mortality and Morbidity. The maternal death rate in England has always been lower than that of Australia; ranging little above four deaths per 1,000 births, in comparison with Australia's five deaths and over. About 10 years ago the direct attack on the problem there seemed to be producing even better results, and the maternal death rate fell from over four in 1918-1919 to 3.8 and 3.9 for the following four or five years. When Dame Janet Campbell was congratulated in Australia in 1929 on this success, she replied that she feared the rate was rising again, and figures now available show that by 1929 they had again reached 4.33 per 1,000 births, and have since continued to remain high. In England also the deaths from sepsis constitute about one-third of the total maternal deaths, and these have fallen and risen in almost exact conformity with the mortality as a whole. This inability to prevent or control sepsis in childbirth is one of the most vexatious and distressing aspects of the problem. Last century, sepsis was an equally grave problem in surgery and midwifery; during the past 30 years it has almost been abolished from general surgical wards. Yet there has been very little, if any, improvement in obstetric practice. The most recently published English figures reveal that in 1855-1864 the total maternal mortality was 4.6 per 1,000 births, of which 1.6 were due to sepsis, and in 1925-30 the figures were respectively 4.2 and 1.7.

Limited Knowledge

It is still true that our knowledge of the origin and spread of puerperal infection is limited and inexact. Notification of cases of sepsis, which has been in vogue here since 1898, and in England and elsewhere for a lesser period, has not been successful in reducing the frequency of infection. This is due partly to the difficulty of defining puerperal sepsis, partly to the difficulty of securing early notification, and also the absence of administrative machinery for investigation. In fact, the National Health Commission found that in New South Wales, where no such notification had been introduced, the mortality was no worse than in any other State. It is recognised that contact infection from bed to bed, so rampant last century, is nowadays a rarity; recently controversy raged for some years regarding auto-infections, and still later the discovery of nurses and doctors who were carriers in their noses or throats of the streptococcus haemolyticus (the great bacteriological cause of the infection) led to the hope that the wearing of masks would prove an effective preventive measure. Further research, however, has only made the position more confused. Partly for this reason, Dr. Robert Fowler, of Melbourne, recently suggested that the Sydney Obstetric Hospitals should be made responsible for a prolonged research into this particular question of sepsis, and Melbourne hospitals should undertake a similar duty for the toxaemias of pregnancy. Such pooling of resources and subdivision of effort seem to be one of the first essentials for any advance.

[In the second article of this series, the author will discuss the professional and economic obstacles to a solution of the problem.]

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TRAGEDY OF MATERNAL MORTALITY

Need To Awake Public Opinion

FACTS MUST BE FACED

This is the second of a series of three articles specially written for "The Advertiser" by a foremost authority on the problem of maternal mortality, which is exercising the minds of the Federal and State Governments, and is being investigated with increasing earnestness by the medical profession throughout Australia.

By

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Everyone recognises the wisdom and the justice of the plea for better obstetric service for expectant mothers. But difficulties arise with any attempt to put this into practice. Most authorities now agree that the best results can be obtained in properly conducted obstetric hospitals, partly through pre-natal care, partly through better facilities for proper natal treatment, and partly through the rest from domestic anxiety given to the poorer mothers.

For instance, figures show a steady rise in mortality in the five year age groups from 25 up to 40. In an address given at King's College Hospital, London, last year, it was stated that at the General Lying-in Hospital, Lambeth, nearly 26,000 mothers were attended in the 10 years from 1920 to 1929 with a mortality rate of 1.31 per 1,000 births. Similar figures for such hospitals in Sydney and Melbourne were given to the Royal Commission in 1926, though for smaller numbers. At the same time, evidence showed that already 52 per cent. of mothers in Australia were attended in hospitals, the proportion varying from 41 in New South Wales to 62 in Western Australia. But there are hospitals and hospitals. One cause for concern in Australia has been the number of small —and often insufficiently staffed—maternity hospitals that have arisen since the passing of the Maternity Allowance Act. The provision of sufficient hospitals with adequate treatment facilities, equipment, and staff, involves financial expenditure that any Government or local authority would quail at.

In South Australia from 1923 to 1927, a medical committee worked hard at a scheme for a women's block at the Adelaide Hospital to provide pre-natal clinics, accommodation for women in childbirth, and the teaching of medical students and nurses. Much time and thought were given to the preparation of the plans, but the land behind the Dental Hospital allocated for the purpose by the Government of the day is still lying idle, because the last of the loan money available was diverted to another purpose. And whereas the public acquiesce in the Commonwealth Government spending £1,000 for a Nutrition Research Laboratory for animals, and the State spending £250,000 for a new Parliament House, would the authorities dare suggest any large sum for such a women's block today? This is said with no desire to be critical of the Government; any Government can spend money only as the general public approves or demands. And maternal welfare as yet excites no public demand.

Prenatal Care

Again, medical opinion during the past 20 years has rightly extolled the valuable aid that pre-natal supervision of the expectant mother can give in foreseeing and preventing those complications of pregnancy and childbirth which increase maternal mortality. And the necessity for this in their future practice has been emphasised to medical students. Mothers also are being educated to its value, and clinics have been established. Just as some of us were beginning to wonder why there was no more rapid reduction in maternal mortality as a result of these efforts, two papers were read at the Bournemouth meeting of the British Medical Association last year on the subject, "Are We Satisfied With the Results of Ante-Natal Care?" These papers and subsequent discussion and correspondence show how easy it is to pass resolutions and use those words "pre-natal care"—just as the old woman used that blessed word Mesopotamia. We must emphasise more and more the words "adequate" and "efficient" when we talk of pre-natal care.

The Professional Aspect

When we think of better obstetric care, most of us (and rightly so) think of better provision to enable mothers to receive proper medical attention. Yet it must be remembered that the practice in England is designedly based on the majority of women being attended by properly trained midwifery nurses and not by medical practitioners (so long as the case is normal), and this policy is maintained there both by tradition and economic conditions. As has been said, the maternal mortality of England is lower than that of Australia, and a great fluttering of the dovecotes occurred a few years ago when it was shown that the mortality among patients attended by midwives was lower than among those attended by medical practitioners. Even allowing for the contention that the latter included difficult cases handed over by the midwives, the comparison was striking. It must also be remembered that in Australia in 1913, when the Maternity Allowance Act had just been passed, 63.2 per cent. of women in childbirth were attended by medical practitioners, and that the proportion rose year by year till 79.3 per cent. of mothers were so attended in 1924. Yet there was no reduction in the maternal mortality. This is not written in disparagement, but in praise of the medical profession, the members of which face in silence conditions in which they know the dice are loaded against them. It is written by a medical practitioner who, from personal and sometimes heartbreaking experience in country, suburban, and city practice, has a first-hand acquaintance with the tragedy and perplexities of the present situation. But the solution will come, not by burking facts, but by facing them; not by criticism but by patient co-operation in ascertaining facts and in using them to the best advantage.

The Human Element

In a recent report, the British Departmental Committee analysed the history of 2,000 women who had died as a result of child-bearing, and found that nearly 1,600 deaths were due to the human factor alone, while 400 were due to intercurrent diseases. The 1,600 showed the same proportion of sepsis, toxaemia, and other accidents that is familiar to all. Further analysis in cases where sufficient history was obtainable, showed that in 626 of these there was a "primary avoidable factor" a point at which deviation from normal occurred which could have been foreseen but was missed until treatment was necessary. In some cases, this was due to lack of pre-natal supervision, in others because this was not thorough enough to be efficient, and in others, again, because the patient failed to carry out instructions. Here enters that varying human factor so difficult to estimate and control. Lack of foresight may occur from carelessness due to temperament, from unavoidable ignorance, from lack of training or experience, or from insufficient acquaintance with all the facts of the case—and any of these may exist in patient, nurse, or doctor. Yet this factor accounted for 39 per cent. of the deaths directly due to these 2,000 labors. And we can only hope to reduce this factor gradually as every death in childbirth is systematically and confidentially investigated, as has been recommended in every Australian report. But any such investigation is useless if conducted by legal methods where everyone concerned is on the defensive, or by routine where red tape rules. It must be a personal investigation conducted by a medical graduate of experience with a constructive outlook.