to indicate whether fatal eclampsia, shock, abortion, ectopic gestation, etc., are individually more common than they used to be, although in some sources abortions are considered to be much more numerous.

A series of 2,000 fatal cases analysed in the departmental report mentioned above indicates that in 626 cases (31.3 per cent.) there was a "primary avoidable factor," such as (*a*) inadequate ante-natal care by the patient or doctor; (*b*) error of judgement on the part of the doctor; (*c*) lack of reasonable facilities (presumably in emergencies in outlying districts); and (*d*) negligence on the part of the patient or her friends. The fault is placed upon the doctor in 283 cases, approximately (14.15 per cent.), and on the patient or her relatives in 269 out of the 626 cases. So far as fatal puerperal sepsis is concerned—for example, septicaemia or peritonitis—it appears that 85 per cent. are due to *Strept. haemolyticus*, and this germ, so I understand (see H. G. Langdale-Smith's letter of December 17th, 1932, to the *British Medical Journal*), is found in the genital tract of many women who do not become septic. If this be the case, and bearing in mind that it is accepted that the organism may be sprayed by the doctor or nurse, to say nothing of the parturient herself, her husband, mother, and family, the other two factors leading to the clinical condition—namely, the locus minoris resistantiae (excluding tears) and the patient's general resistance—are the most important. In my humble opinion the latter is the key to this problem.

Unfortunately, the general resistance is not determined solely by the nutrition, or the social status, because one of the "black" areas in London for maternal mortality due to sepsis is possibly the most affluent. If anything, the patient's attitude to the pregnancy and labour is of fundamental importance. In support of this I may mention only one instance—namely, that puerperal sepsis occurs more frequently in unmarried women than in their less embarrassed sisters. Undoubtedly pain lowers the resistance, and although an anaesthetic may prolong labour, the beneficial effect psychologically makes it worth while. It has been suggested that puerperal sepsis should be tackled by submitting pregnant women to a skin test on the lines of the Dick test, and then immunizing the susceptibles; but so far nothing tangible has been accomplished.

There are a few intriguing points in this subject—namely: (1) Why has Denmark such a low maternal mortality rate? And what steps have been taken to find out why, in England, the Queen's nurses can boast in 1928 a low figure of 1.9 per 1,000 births? Does this figure exclude the cases sent to hospital? (2) Fifty per cent. of septic cases occur in "spontaneous" labour. Are they due to autogenous infection or because the patient has had her hands on the perineum? (3) What is the death rate of the various diseases which have the *Strept. haemolyticus* as a causal agent? (4) Does the stress of "getting round," and the patients clamouring at the surgery, flurry the doctor, or can hospitals, where the time factor is of little consequence, show better figures than the general practitioner? (5) Are we 14.15 per cent. away from perfection, and how can we expect perfect parturients with perfect friends? (6) Perhaps antisepsis and patience may help the 14.15 per cent.?—I am, etc.,

Hull, Feb. 7th. L. I. HARDY.

SIR,—We owe Sir Comyns Berkeley a debt of gratitude for his proposal that the profession should voice its views on maternal mortality, protected, if desired, by anonymity. I suggest two main lines of thought: (1) The insufficient experience (as opposed to teaching) of the present-day medical student and post-graduate. (2) The failure on the part of modern obstetric teachers to stress the all-important distinction between things which have stood the test of time or experience and have earned the right to be looked upon as a *sine qua non* of good midwifery, and those innumerable new theories and discoveries whose value is still unproved.

The first is the more important. It must almost inevitably fall to every doctor, sooner or later, to deal with midwifery cases, and no amount of theoretical teaching can fit him for this responsibility. Midwifery is a subject of which almost everyone, unfortified by adequate practical experience, is afraid. How many obstetric disasters have been precipitated because the ignorant accoucheur, faced by what he took to be a crisis, became afraid! No one should undertake midwifery who cannot recognize and rotate an occipito-posterior position, deal with a shoulder presentation or a case of placenta praevia or eclampsia, or remove an adherent placenta—for all these may occur in general practice out of the reach of specialist assistance. Only a sense of competence to deal with all these will make it possible to approach a case with the equanimity without which good midwifery is impossible or the courage required to do nothing.

This result can only be brought about in one of two ways. Either midwifery should be taken out of the hands of the general practitioner and handed over to those specially experienced in it, or cases should be shared more reasonably between pupil midwives (who in a large proportion of cases do not intend to practise) and medical students. To adopt the first alternative would be little short of a national disaster. The second might save the situation. It is equally important to increase the number of resident hospital appointments available. Most young graduates can obtain house-surgeon appointments, although the majority have no intention of practising surgery. It seems anomalous, therefore, that in the one branch of medicine where special experience will almost inevitably be required there should be so little opportunity of obtaining it. Post-graduate classes do not meet the case: the students get little or no practical experience, and their attention is focused on the abnormal rather than on the normal. It will take time to create new resident appointments; but could not something be done at once by increasing the responsibility of the medical student, say, during his last month of midwifery (the time, if necessary, being extended for this purpose) and allowing him during that month to deal with such abnormalities in his cases as would ordinarily be entrusted to a junior obstetric resident? He knows just as much then as he will know when (if ever) he is appointed to his first obstetric post.

If I seem to have over-emphasized this aspect of the case, my own experience as a student is my excuse. I attended the usual twenty cases, but delivered only seven, all the others being abnormal, including hydrocephalus, central placenta praevia, and eclampsia. This so affected my outlook on midwifery that even now I find it difficult to undertake what purports to be a normal confinement with the same confidence with which I should approach a major surgical operation. I went to my first resident obstetric appointment ignorant of the meaning of full dilatation of the cervix, and believing it meant the os was so many inches across. In my case, however, a series of resident obstetric appointments enabled me to overcome, to some extent, the defects of my training. But I feel great sympathy with the patients whose doctors, through lack of adequate experience, know as little as I did when I qualified, and with the doctors themselves my sympathy is scarcely less.

Lest I should seem to cast an aspersion on my medical school, I merely sign myself

Z.,

February 14th. F.R.C.S., F.C.O.G.