In My Own Time

Domiciliary obstetrics

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British Medical Journal, 1979, 2, 377-378

In 1942, when I qualified, domiciliary obstetrics was quite common in the United Kingdom with a third of all confinements taking place at home. But I saw very little of this in my training as a medical student in Aberdeen, where the emphasis in teaching was on hospital confinement with a well-organised service caring for the needs (including family planning) of all sections of the community. Six months as a house physician, followed by four years as a doctor in the Royal Air Force, meant that I had no further experience of obstetrics until I returned to Aberdeen in 1946 to begin my specialist training. I then became part of the maternity service that I had seen as a student, and it was even more impressive at close quarters. There was still a domiciliary obstetric service in the city of Aberdeen, with general practitioners, obstetricians, and community midwives looking after women in their own homes, but I have no recollection of being concerned with the care of these patients.

My training was centred on the new maternity hospital at Foresterhill and its associated maternity homes in the city. There, in the face of unexpected obstetric complications (and there were plenty of these), it was a great comfort to have everything to hand—skilled nursing colleagues, an anaesthetist, access to radiology, sterile packs, good lighting, the ability to put the patient in the lithotomy position on a proper operating theatre table, and so on. And so my early training continued in this favourable setting, with Dugald Baird steadily building up what was undoubtedly one of the finest maternity services in Britain—with his emphasis on a scientific approach to clinical excellence. He had no wish to belittle the good work of the conscientious general practitioner, working either in the cottage hospital or in domiciliary practice, but it became increasingly difficult for them to match the truly comprehensive service offered by the hospitals in Aberdeen.

My appointment as first assistant in Newcastle upon Tyne in January 1950 brought an abrupt change. Obstetrics differed in many fundamental ways. Here was a part of the country with relatively few maternity beds, dispersed centres of population, and a considerable domiciliary confinement rate. The Princess Mary Maternity Hospital, with its long and distinguished tradition, received emergency cases from a wide area of the north-east of England. But the striking difference for me was the highly organised and busy obstetric flying squad. Now I was to see domiciliary obstetrics—at least the complicated side of it—at first hand, and frequently.

Flying squad to the rescue

By the time I arrived the Newcastle flying squad was well established. The original suggestion had come from Farquhar Murray, who had been appalled by the number of women brought many miles by ambulance to the Princess Mary Maternity Hospital because of complications in the third stage of labour—usually with the placenta still in the uterus. Some were found to be dead on arrival in hospital. He argued that it would be much better to send a skilled medical and nursing team out to the woman's home to deal with the emergency on the spot. It fell to Frank Stabler and William Hunter to establish the ground rules and set the flying squad in motion, and this they did superbly well. No one below the rank of senior registrar accepted the calls for help, and the obstetrician was always accompanied by a consultant anaesthetist and a senior, experienced nurse. We carried three pints of group O Rh-negative blood and drums of sterilised towels and instruments. Mostly, we travelled in one car. The fundamental principle was to deal with the emergency—whatever it might be—in the patient's home, and not transfer her to hospital. My memory of these early years in Newcastle is still vividly with me—a distinct feeling of having gone in at the deep end with no experience of dealing with such dire emergencies outside hospital.

The calls by day interrupted ward rounds, outpatient clinics, and teaching sessions but the night calls made the deepest impressions. As I look back on that period I remember especially the urgent telephone summonses in the small hours followed by the drive through the empty, sodium-lit streets, dreading what awaited me at the journey's end, and seriously doubting my ability to cope in unfamiliar surroundings. These calls are forever linked in my mind with an empty, sinking feeling that was with me until the particular problem was resolved. The saving grace was my mentor and tutor, Frank Stabler. He simply loved the flying squad and all it stood for. His experience in this work was unmatched, and he was always ready to discuss general principles or, if need be, the details of a particular case in which I had found it difficult to decide what was the best thing to do. He was a great support and a fine teacher.

Four weeks after my arrival in Newcastle I set off on my first flying squad call to a small pit village 20 miles north of the city. The GP had applied forceps and had failed to deliver the baby. It was a large child, the head high and lying in the occipito-posterior position. The perineum was bruised and oedematous. I wasn't certain that I could distinguish the fetal heartbeat from the mother's rapid pulse rate. With the confidence of youth, I had the anaesthetist put the mother to sleep and, with some difficulty, the nurse and I swung her round over the edge of the sagging bed into something approaching the lithotomy position and held her in that position with the complicated harness known as the "obstetric help." Scrubbed and gowned, I managed to turn the head into the occipitoanterior position and delivered the baby with moderate traction. I can still remember the very moment when I knew that the head was going to come

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down through the pelvis and that I was going to be spared the acute embarrassment of a failed second attempt to deliver the baby. As I handed the child to the nursing sister I could feel no heartbeat and the room was ominously silent as I delivered the placenta and set about repairing the episiotomy. The first whimperings came 10 minutes later as I finished my part of the job, but it was fully half an hour before the child cried properly. It was not an unreasonable ending to a difficult problem and the family doctor was grateful. We followed him by car down the village main street, passing groups of miners on their way to the early morning shift, and ate breakfast in his kitchen. As we set off home, he handed me a parcel of home-cured bacon, a gift from the patient's husband. My concern was for the future wellbeing of the child, whom I didn't see again until I met her by chance when I was visiting her doctor some 20 years later. Clearly, she had not suffered in any way from her adventurous entry into this world.

Some difficult deliveries

That was the beginning, a good beginning in fact, but over the next 10 years there were to be other experiences—many were with patients whose lives hung in the balance, some had an amusing side, and a few were frankly harrowing. Scanning the pages of the emergency service record from 1950 to 1960—a scrupulously kept account of the work of the flying squad during that decade—I found that the frequency of the calls and the seriousness of many of the problems we dealt with were even more impressive than I had remembered. At the busiest time we were answering 150 calls a year, and not infrequently that meant two or three in the space of one 24-hour period with much dislocation of our work in hospital.

Reading the record brings half-remembered events back into sharp relief—mostly I can see the houses, the rooms, and the very women as though it had all happened yesterday. Retention of the placenta with heavy blood loss and a severely shocked woman was by far the commonest reason for our being called out. Rapid blood transfusion, followed by manual removal of the placenta under a well-administered general anaesthetic, took care of the immediate crisis, but inevitably some of these women in later years must have suffered to some degree from hypopituitarism (Sheehan's syndrome). I shall never forget one such case; I have no need to go to the record for details. Summoned from my antenatal clinic in the late afternoon, with the nursing sister and anaesthetist in my car, we cleared the city ahead of the early evening traffic. Twenty-five minutes later we drew into the street in the small town where the young mother had delivered her first baby at 7 o'clock that morning; a retained placenta had been removed manually by the general practitioner. As we approached the house we saw that the curtains were drawn. The young girl had died of haemorrhage and shock 15 minutes before we arrived. Within three days of this tragedy I had to deal with two other young women in their own homes with similar sorts of third-stage problems. Both survived.

Then there were undiagnosed twin pregnancies, where the uterus would clamp down on the second twin lying transversely with one arm down the vagina and all the liquor drained away. These were difficult cases to manage, for it was only too easy to rupture the uterus. One unfortunate woman did have a ruptured uterus and after resuscitation had to be brought back to hospital for a hysterectomy.

We always had to be careful about diagnosis, and I quickly discovered that it was dangerous to accept things at their face value. Once, when I was called to a patient with postpartum haemorrhage one hour after delivery, the general practitioner described how he had expressed the placenta—which he had inspected and judged to be complete. The nurse had wrapped it in paper and placed it on the fire. Ten minutes later the patient bled a little and collapsed. When I saw her, her blood pressure was barely recordable, and she was very shocked. Rapid

transfusion of two pints of blood had no effect on her condition; if anything, she was deteriorating. Thinking that there might be a retained cotyledon, or even a rupture of the lower uterine segment, I made a gentle vaginal examination and there was a complete inversion of the uterus through a tight, oedematous cervix. She required seven pints of blood and under a light general anaesthetic it took me half an hour to reduce the inversion. Once it was back, she recovered dramatically but my right hand was so painful that I had to have the anaesthetist drive the car back home and I couldn't write for two days.

Finding the way

Added to the obstetric problems was the difficulty of finding the patient's home. We usually managed well, but now and then we got lost. For some reason that I cannot now remember, the nursing sister and I set out on our own around 3 am agreeing to meet the anaesthetist at the patient's house near Bedlington. It was bitterly cold and raining hard and, although we both knew the area reasonably well, we just couldn't find the street and there was no one around to ask. We made two or three attempts to get help from people in their houses, but they either refused to answer the doorbell or said they had never heard of the street we wanted. We circled around desperately and happened on a nightwatchman sitting over a coke brazier on a building site. He gave us helpful directions, but we rapidly got lost and to our embarrassment turned up at the same building site 10 minutes later. We sped rapidly on, not daring to ask him again. Eventually, a group of miners who had just surfaced from a local pit headed us in the right direction and we arrived at the patient's home fully an hour after the anaesthetist. He had the blood with him and had given two pints by the time we arrived. The family doctor had managed to expel the placenta and the patient was sitting up in bed happily holding her baby.

We were lucky on that occasion. The outcome could well have been different. In time we learnt to arrange for relations or neighbours to be strategically placed with newspapers held aloft to catch our headlights at night. Generally, we found it better to ask children rather than adults for directions. Children have a remarkable knowledge of their locality, and if they happen not to know where a particular street is they will say so. Adults are less likely to admit ignorance and, in their desire to be helpful, may give poor or inaccurate directions.

It was an exciting period, a hectic period. It was a time when one really did learn how to deal with major obstetric emergencies. What we were seeing was but the tip of the iceberg. For every patient we were called to see there must have been many others whose blood loss or injuries, though not severe enough to warrant calling the flying squad, resulted in chronic ill health from anaemia, infection, or both. Many lives were saved but there were some very near misses. No matter how quick we were, there was always some delay in getting out to the home and time was never on the patient's side.

These are memories of the past. Those days are over. No doubt many women had their babies safely at home and enjoyed the experience. But when difficulties did arise during a home confinement they could be very serious. For 10 years I happened to deal with the complications of home confinement and this made a deep impression on me. It is a side of obstetric practice that I would rather not see return.

WORDS CATARACT (*G kataraktēs*, a precipitous, *s* waterfall) in its non-medical sense means a large waterfall, especially one falling over a precipice, as opposed to a cascade, which is one of a series of small waterfalls. In medical terminology a cataract is an opacity of the crystalline lens or its capsule or both. An obsolete usage of cataract was for portcullis (door/sliding) and derived from its downwards fall, and it is from here that the medical term stems. Just as a portcullis shuts off entry into the castle, so does a cataract occlude the entry of light into the eye. Ambroise Paré (c 1550) used both terms: "cataracte ou coulisse" (OED).