

then born also had ophthalmia. Some people were not warned by experience.

In announcing the decision of the Board to severely censure the midwife, and to ask for a report in three and six months' time from the Local Supervising Authority, the Chairman said that there was no doubt the charge was amply proved, and the same thing happened three years ago. Under such circumstances it was the rule of the Board to strike the midwife off the Roll, but the Inspector, Miss Harrison, who was present, had told the Board that she thought the midwife had taken the matter to heart, and the Board had, therefore, decided to give her another chance.

We think that a midwife who has received instruction enabling her to pass the examination of the Central Midwives' Board, is deserving of severe censure if she does not immediately secure medical advice in a case of ophthalmia neonatorum, but it seems to be commonly assumed, as was apparently done by Mr. Bertram in this case, that where ophthalmia neonatorum occurs it is through carelessness on the part of the midwife in attendance, whereas it is well known that the most usual cause is infection contracted by the child at the time of its passage through the parturient canal of a mother suffering from an infectious discharge. A midwife is to blame if she does not adopt every means in her power to prevent or counteract the effect of such infection, but the *cause* must be sought for in the infectious condition of one or both parents, and should not be attributed to the midwife. A midwife is well advised if she has once attended a woman whose child has developed purulent ophthalmia to refuse to attend her again unless she also engages a medical practitioner.

#### CENSURED.

Mrs. Annie Walker (No. 6068) who appeared before the Board, and was accompanied by her son, a Sergeant-Major in the Army, was censured for not securing the attendance of a registered practitioner in a case of abortion, and for douching the patient with an appliance which she had not disinfected. Mrs. Walker explained that the case was over before she arrived at the house, and as everything was perfectly normal she did not consider it requisite to call in a doctor.

The Chairman advised Mrs. Walker to study the rules. Midwives were apt to look on the rules as their enemies, but, in reality, they were their best friends. If they kept them no one could touch them.

#### CHARGES NOT PROVED, NO ACTION TAKEN.

In this case, Rachel Lewis, a midwife at the Monmouthshire Training Centre, was charged with negligence while in attendance on Mrs. Alice Jansen, in two respects. (a) The placenta and membranes not having been expelled two hours after the birth of the child, she did not explain that the case was one in which the attendance of a registered medical practitioner was required or hand the form of sending for medical help to the husband or nearest relative, and (b) that the patient suffering from post partum hæmorrhage she did not give a similar explanation to the relatives. Miss Lewis, who, with the Superintendent of the Home, Miss Barry, was present, was ably

defended by Mr. Hornby. The first point for the Board to decide was whether, as a medical man had been notified that the woman was in labour Miss Lewis was responsible, and amenable to the jurisdiction of the Board, or whether she was not acting as a monthly nurse.

Mr. Bertram explained that the Local Supervising Authority for the Borough of Newport applied to Miss Lewis for information as to a case attended, and as to why she had omitted the observation of certain rules. Miss Lewis referred the Local Supervising Authority to Dr. Hurley, the Medical Officer of the Home, whereupon it made certain investigations and found a *prima-facie* case against Miss Lewis.

Mr. Bertram explained that he had written to Dr. Hurley, who had replied that he had been appointed medical officer to Miss Barry's Home, and every patient who engaged there *ipso facto* engaged him unless she said she wished for another doctor. The patient, who was approaching her confinement, applied to Miss Barry's Home for a nurse, and on the card which she signed were her own name, the name of the doctor, and that of the nurse.

Mr. Bertram claimed that the Midwives' Act applied to all midwives where no doctor had delivered the patient. Unless the case was what was known as a doctor's case the Act ought to apply. He contended that Miss Lewis acted as a midwife, that she was a midwife, and that the Act ought to apply. The woman in attendance at a confinement was one of two things, an unqualified woman, practising illegally, or a midwife under the jurisdiction of the Central Midwives' Board.

The Board having deliberated, decided that the arrangements of the Monmouthshire Training Centre did not exempt them from the jurisdiction of the Board, and proceeded to hear the evidence.

The patient, Mrs. Jansen, said Dr. Hurley's assistant called on March 17th, the baby having been born on the 15th. Dr. Hurley only called on the 9th day. Dr. Hoey was called in on the 8th day, and attended her for a month or six weeks.

Mrs. Brooks, a friend of the patient, also gave evidence, and asserted that on March 19th a small piece of placenta was passed. This was shown to the nurse, who said "That is what I was waiting for."

Dr. Howard Jones (the Medical Officer of Health), called upon her subsequently, and put down what she said.

The declaration of Dr. Hoey was read, in which he stated that on March 22nd he found the uterus enlarged and tender.

Miss Lewis having given her evidence, Dr. Hurley deposed that he first visited the patient on March 16th, and described her condition as normal. His assistant did not see her. He visited her on March 22nd and 24th, and found that on March 23rd Dr. Hoey had called and examined her.

After deliberating, the Board found that neither charge was proved, and decided to take no action.

No other decision was possible on the evidence, and Miss Lewis is to be congratulated on this vindication, and also on the excellent way in which her solicitor presented her defence.

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