TOWARDS BETTER POSTNATAL CARE

by

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One of the usual questions one obstetrician asks another in this country, while visiting a hospital is, "well, how many days do you keep your normal delivery cases?" And supposing the answer is "five or six days", then one somewhat carelessly adds, "oh, in our hospital we cannot keep them even for three days." When one pauses to think what this means, it does not appear such a trivial matter. A woman, whom we have been assiduously and painstakingly following up through nine months of pregnancy and then labour, whom we have coaxed and cajoled and even bribed to attend the clinic, very strangely and peculiarly enough we cease to take any interest in her or her newborn baby barely three days after labour. We get rid of her quietly, handing over a discharge card, advising her to attend the postnatal clinic six weeks later. With what accuracy do we calculate our neonatal, perinatal, and even maternal mortality and morbidity figures? As far as the undergraduate is concerned, the care of the normal puerperium and the newborn baby has become a purely academic matter to be discussed at lectures and clinics, and out of the twenty labour cases he attends, he is fortunate if he can follow say the involution of the uterus in one case. Thirdly there is no doubt that this practice of discharging normal labour cases so soon after delivery without making any provision for their aftercare, definitely contributes to an increase in gynaecological disorders including infections. Fourthly most of these patients go home much against their will and feel that they have gained very little by having the delivery in the hospital and hence they are likely to lose their confidence in the doctor and the hospital. They do come back to us later in case there is any trouble but then only as a last resort, not because they like to, but only because they have to.

All over the country we are faced with acute shortage of hospital beds and one of the solutions the obstetrician finds for this problem is to discharge the normal cases earlier and earlier still, until very soon it threatens to become an out-patient delivery service. Thus the obstetrician is taking the most easy way out. Instead of taking this obvious way out of the difficulty, it is up to those of us in the larger hospitals to take steps to solve this problem as best as we can under the circumstances

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instead of feeling lost and helpless. The most obvious but rather impracticable way is to have more maternity hospitals and beds—impracticable because these are days when every medical speciality is clamouring for more beds and the obstetricians cannot have more privileges than the paediatrician or the phthisiologist and so on. The second solution is to provide convalescent homes attached to hospitals. This is a very practicable measure in many big cities where accommodation may be available in the suburbs. A third alternative is to establish domiciliary maternity services. It may be suitable for the middle and upper classes but most unsatisfactory for the poorer classes who however form the majority of hospital general ward class of patients. The last solution which appears difficult on first considerations is most suitable under the circumstances which exist in the country at the moment. In all cities today, there exist a number of maternity and child welfare centres established and run by various voluntary and governmental agencies. For example, in Nagpur, there are centres run by the Red Cross, the Matru Seva Sangh, the Nagpur Corporation and at least three large sized hospitals. The existing facilities and personnel are perhaps sufficient for this city, but the work has to be properly organised, as at present there is absolutely no co-ordination or co-operation between these various agencies. It is here that the obstetrician plays or could play an important role. It is also high time that we broke up the contact tight partition between the MCH and hospital obstetric services, that is, between preventive and curative obstetrics. Maternal Welfare Committees who co-ordinate and direct the activities of these various agencies exist in cities in all civilised countries, not only at the city level, but at district and state level also. We are all aware that these Committees play a very useful part in not only co-ordinating the work of various agencies but also make surveys, reports on mortality and morbidity rates and take part in various other ways in the cause of Maternal and Child Welfare. And yet in India we are lagging far behind. I do not know of any city where such Committees or similar committees exist. It may be that we obstetricians are pre-occupied and overwhelmed by many other pressing problems but it may also be due to that lethargy and mental inertia which may well prove to be an important stumbling block in the pathway of our progress. Going back to our basic problem of better postnatal care, the Maternal Welfare Committee can help by arranging for the domiciliary care of these patients discharged from the hospital through home visits from the various centres and in this way the various institutions can keep in touch with their cases. Regional Antenatal and Postnatal Clinics should be organised in such a way, that the patients need not all crowd to the hospitals and waste time and money to attend clinics far away from their homes. Many other local problems can be solved by the individual Committees and help can be more easily obtained from Govern-

mental and other agencies by these Committees rather than by individual institutions. All this and more work is waiting to be done but someone has to take up the initiative and to my mind that someone is the obstetrician. Wherever Obstetric and Gynaecological Societies exist they should take this work up as a part of their activities. It is high time that we roused ourselves from our complacency and torpor and ask ourselves sincerely and honestly "are we doing all we can and all we should, for our patients who have entrusted to us the care, not only of themselves, but also of their unborn children?"