

Barratt Maternity Home

Northampton



A few glimpses of Midwifery

1936 – 1971

In the beginning:-

It was due to the foresight and generosity of its benefactor, Mr William Barratt, that Northampton and its surrounding counties had the advantage of a beautifully designed and furnished Maternity Home as a separate building in the grounds of and linked to Northampton General Hospital.

An equal debt is owed to the pioneers who, by their skill, hard work and devotion, laid the foundations for and built up the work of the Barratt Maternity Home and the Midwifery Training School.

Prior to the opening of the home in 1936, maternity care had been carried out almost entirely in the patients' own homes, with Mr Holman acting as Consultant Obstetrician. He was joined in 1936 by Mr Salisbury who was expected to become the Obstetrician in charge of the new home. Due to his unexpected death in January 1935, a vacancy arose and Mr Robert Watson was appointed to this post on 29th October 1935. He came from Liverpool and brought with him a Sister Mary Thomas to take charge of Midwifery. On 1st October 1938 Miss Eleanor Hague was appointed as a Midwifery Sister. Shortly afterwards, Sister Mary Thomas left and Miss Hague succeeded as Midwife in Charge. It is to Miss Hague that all the credit must go, for the development of Midwifery and the Midwifery Training School during the following twenty six and a half years.



The opening ceremony of the Barratt on 4th July 1936, was carried out by H.R.H. Princess Alice of Athlone. The ceremonial party included the Earl of Athlone, Earl and Countess Spencer, Lord Hesketh (Chairman of the Hospital Board of Management) and, of course, the very young-looking Mr Robert Watson.

The impressive building was set well back from Cheyne Walk, leaving plenty of parking spaces for Ambulances and the few cars owned by the wealthy. It provided 34 beds for ante-natal and post-natal patients, a nursery and labour ward accommodation.

Ground Floor

The entrance, at the centre of the building facing Cheyne Walk, was beautifully designed and spacious. The entrance lobby, which was furnished with hide upholstered seats, was separated from the inner reception area by a beautifully designed glazed screen. Mr Barratt had spared no expense in the quality of the furniture or indeed the equipment, which was very modern in its era.

Ante-natal and Private Patients' Ward

A wide corridor ran parallel to the front of the building and gave access to two single rooms overlooking the front lawn, on each side of the front door. At the end of this corridor, on the left, was a flat provided for the Midwife in Charge. At the back, adjacent to the flat, was a small room originally used by the Almoner, and then two rooms which were soon to be used as single rooms. The single rooms were used for private patients and ill patients. Eclampsia was quite common, especially during the war years and I well remember helping to 'special' for such patients in strict silence and darkened rooms. The steel structure of the building was not

ideal for sound proofing and the clang of a dropped bedpan on the first floor was enough to trigger off an eclamptic fit in at least one of these patients.

At the far end of the front corridor on the right, was a five-bedded ante-natal ward. Here one of the greatest practical skills, to judge the establishment and progress of labour, was essential in order to transfer the patient to the labour ward at the optimum moment. Vaginal examinations were forbidden and rectal examinations were used to confirm the diagnosis of the presenting part and its descent, attitude and position as well as the dilation of the cervix. This had to be carried out gently and with the minimum of discomfort to the patient. It took all of two months for a pupil-midwife to become proficient at this skill. The patient's posture gave a good clue as to the descent of the fetal head and a change in the patient's breathing and groaning emphasised the nurse's misjudgement of progress and resulted in a rapid ascent in a somewhat unreliable lift to the first floor.

An Isolation Ward was situated at the end of the corridor leading from the front door to the back of the building. This corridor gave access to a single ante-natal room on the right (later to become Matron's office) and a short corridor leading to the staircase to the basement and later to the extension ward corridor. The staircase and lift gave access to the first floor and a small room on the roof. On the right, beyond the lift, were a small bathroom and a linen store. On the left of this corridor was a nursery for P.P. babies (later to become the Tutor's Office) and a ward kitchen with its quite tame mice, a bathroom (which became a path. lab.) and a staff cloakroom.

The corridor at the far end turned to the left to join the 'green corridor'. This gave access first to Gynae/Maternity Outpatients' Department on the right and at a later date to the Private Patients' ward as it turned right to provide the link to the General Hospital.

Isolation Ward

The isolation ward provided two single rooms, a small nursery, bathroom, sluice room and small kitchen which contained a hot water steriliser for bowls and instruments. In the days before antibiotics, puerperal sepsis endangered the mother's life and pemphigus could prove fatal to the baby. Cross infection was a real hazard, so the staff as well as the patients were strictly segregated.

Out-Patients' Clinic

The Out-Patients' department provided ample space for ante-natal clinics in the early days, when most of the ante-natal care was provided in the community. The waiting area was very spacious and was furnished with rows of long, hide covered seats. At the furthest end, from the green corridor, was a reception desk, which separated the waiting area from "Gynae Bureau" which housed all the patients' records. To the left was a minute room in which was closeted a pupil-midwife for two hours during an ante-natal clinic session, with the task of testing specimens of urine. The wall was spattered with drips of green and blue Fehling's and Benedict's solutions. This had boiled up from the test-tubes which were heated over a bunsen burner flame in the test for glycosuria.

To the right of the desk was a corridor which gave access first to an interview room on the right and then to the examination area on the left. At the end a door led to another interview room and the corridor then turned right to lead to the Gynaecological Ward which was opened in 1938.

The examination area had an inner waiting area surrounded by three changing cubicles and three examination rooms. By the mid-1940's the whole examination area became totally inadequate and a belt system was unfortunately the only way to deal with the hundred or more patients attending an ante-natal session. The two interview rooms were used for history taking and the recording of blood pressure, urine test results and weight. Despite the belt system, under the watchful eye of Miss Hague, the personal touch was somehow retained. Miss Hague always chaperoned Mr Watson and despite the hustle and bustle she found time to stay behind after the examination to answer questions and reassure the patients. Foetal hearts could only be heard by means of a Pinard Stethoscope if there was complete silence and I do not recall being at a single clinic when Mr Watson did not emerge from an examination room declaring that the place was like a bear garden – or was it a beer garden?

The Barratt was never behind the times in introducing new ideas providing they were sound and practical and in the late 1940's Miss Hague started Mothercraft and relaxation classes first to teach the staff and then for the patients.

First Floor

The first floor provided post-natal wards, nurseries and labour wards.

Post-Natal Wards

There was one office sited on the left of the staircase and opposite the sluice room – the title of dirty utility was introduced three decades later. This office was used by the senior midwifery staff and the doctors, it also housed the drug cupboard and stationary store. The senior midwife only sat at the desk for giving of reports from the Report Book and the charting of the patients' records each morning. The ring and sometimes the clang of a handbell summoned, all too frequently, the nearest pupil-midwife to the office to be sent in search of missing information required for the patients' charts. It was in the sluice room that each new pupil received a scalded arm as she opened the steam bedpan steriliser and a subsequent reprimand for dropping the almost red hot steel pan.

The corridor parallel to the front of the building gave access to a five-bedded ward at each end and at the front, there were two four-bedded wards on the left and a spacious nursery on the right. At the back on the left was a two-bedded ward, sometimes used as a premature baby nursery and on the right was a nursery bathroom and a minute room for premature babies.

In the post-natal wards the patients were hustled through the daily routines – meals, five vulval toilets, washings followed by breast feeding. After the 2pm baby feed session, all the mothers were tucked down for an hour's rest lying prone to aid ante-version of the uterus. Visiting was strictly controlled at half an hour for two visitors in the afternoon and one hour for husbands in the evening, though Miss Hague would always make other arrangements in cases of difficulty. All babies were breast fed, though extra drinks were given by spoon, as required. If 4-hourly feeds were inadequate, three-hourly or even two-hourly feeds were scheduled but usually feeds were strictly 6am, 10am, 2pm, 6pm and 10pm.

By 10am the babies were all bathed by the staff (the accepted rate was 6 or 7 per hour). When all the babies were out at the 10am feed, the cots and their bedding were all exposed in the nursery to ultraviolet light to reduce the risk of infection. Great effort was put into cleaning to prevent infection. Various ideas were tried for the cleaning of walls and furniture. Dusting with carbolic impregnated cloths was superseded by the use of oil impregnated cloths on the supposition that dust and germs would leave the air and cling to the walls and furniture. In fact, at one stage even the babies were 'oiled', though the theory in this case was not to attract the germs to the babies!

The minute room adjacent to the nursery bathroom was the warm home for many premature babies. Tube feeding was only used as a last resort and feeding was usually by pipette or belcroy feeder. The latter was a graduated glass barrel with a pipette teat at one end and a larger rubber valve resembling a lamb's teat at the other. Gentle squeezing of the valve squirted the feed into the reluctant baby's mouth and sometimes elsewhere. Miss Hague's recipe for very delicate babies was a mixture of Secway, brandy and glucose and a teat smeared with Nestle's sweetened cream persuaded many a reluctant feeder to get started. Despite her abhorrence of all intoxicating liquor, Miss Hague had great faith in the odd drop or two of brandy for resuscitating babies – it certainly made most babies gasp!

The staff worked at great speed in the mornings to complete all the routine rounds in order to dash up to the small room on the roof for a hilarious party of tea and breakfast left-overs and sandwiches of a strange concoction of Nestle's sweetened cream and cocoa powder. The first nurse on duty in the morning made a dash for the first floor kitchen to scrounge breakfast left-overs, which she hid somewhere in her ward for this 'levenses feast'. Pupil-midwives showed great ingenuity in finding hiding places for items in short supply, especially nappies. After returning to the Barratt after five years' absence, I found some nappies in my favourite hiding hole in the basement. This basement was also used for the storing of cleaning materials and a maternity unit for numerous wild cats.

Labour Wards

The Labour Ward was originally situated on the first floor over the Isolation Ward and was separated from the Gynaecology Ward by doors which were only opened to allow the transfer of patients to Gynae Theatre for Caesarean Section.

There were two delivery rooms, one first-stage room, a staff changing room, a small sluice room and an admission room. The latter acquired the title of 'slab room' because it contained a six foot porcelain slab raised about two feet above the ground – a hygienic surface on which each newly admitted patient should lie for her admission bath. I doubt if it was ever used for this purpose, but it was very useful for disinfecting and hosing down of the thick red rubber mackintosh sheets which used to be placed under the bottom sheets of every hospital bed.

At the Gynae end of the labour ward corridor the electric water sterilisers for bowls and instruments were situated together with the large urns for hot and cold 'sterile' water. Dressings were prepared and packed in metal drums, by the nurses. Originally this was done by the night staff, who took these over to the General Hospital each morning.

Later they were sterilised in a large steam autoclave in a room off the green corridor. This was a formidable looking bit of equipment which resembled a railway steam engine. This job was carried out by the porter six days a week, but on the Sabbath this terrifying operation was delegated to the midwifery staff. I well remember following the written instructions to get up steam, then taking to my heels along the green corridor

to the safety of the Barratt. In those days bowls and instruments were boiled for twenty minutes and sharp instruments were boiled for two minutes then stored in tanks of methylated spirit. CSSD and disposables like test tube babies were among our wildest dreams. Each morning and evening a steel douche can with attached rubber tubing was boiled and hung up on a mobile stand ready for a hot intra-uterine douche which one Consultant would request to control post-partum haemorrhage. Fortunately the bleeding has usually stopped by the time the frightened pupil staggered in with the equipment. The built-in instrument cupboards in the corridor housed an array of ghastly destructive instruments, such as a cephalotribe, decapitation hook and cleidotomy forceps. These were very occasionally used for extracting a stillborn infant in a case of obstructed labour. In those early days, a caesarean operation was a hazardous operation for both mother and baby.



The resuscitation of babies was a very dramatic procedure. A metal mucus extractor was used and oxygen was administered by funnel. If the weak drop of brandy did not produce the first gasp, the baby was immersed alternatively in hot and cold baths. Manual artificial resuscitation was carried out by holding the baby's head and buttocks and flexing his spine. Intra-gastric oxygen, using a double tube, was introduced later before endo-tracheal oxygen was considered safe and practical.

For many patients labour was long and arduous, partly because of malnutrition and deformed pelves and partly because of the mother's utter fear. Mist, Potassium Bromide and Chloral was given by midwives and was quite helpful, but only in early labour. Morphine was sometimes ordered by the doctor and was very effective, but skilled judgement in the timing was needed in order to prevent neonatal asphyxia. In the early 1940's, nitrous oxide and air was administered by duly qualified midwives using the approved Minnitt's apparatus. Pethidine was introduced about this time, and eventually midwives were allowed to order and administer it, though legally it had to be prescribed by a doctor in a Consultant Unit.

For the first twenty minutes after delivery of the baby, the midwife stood with one hand on the patient's abdomen above the fundus uteri to 'control the uterus' and prevent it from filling with blood. She was forbidden to 'fiddle with the fundus' and under no circumstances should she pull on the cord. She and the mother waited patiently for the signs of separation and descent of the placenta. The placenta was then expelled by maternal effort and fundal pressure. A second degree tear was regarded as the result of inefficient midwifery, though some allowances were made if the baby was delivered face to pubes. In any case, the injury was unpopular with the ward staff as well as the mother because it carried a penalty of vulval toilets for ten days instead of the usual seven days.

Development of the buildings

At first the Barratt was underused, but after a few years the work increased rapidly and the war brought many patients to the area from the bombing and devastation of the London area. Many small maternity homes

sprung up in the county to accommodate these evacuee ante-natal patients and the Barratt catered for any of these ladies who bordered on abnormality. From the end of the war, Corby steel town developed rapidly and many unemployed men and their families came down from Scotland in search of jobs and homes. Not only did this increase the number of patients but the percentage of abnormal work increased drastically. Because of sheer poverty, many of the women had been severely undernourished. Rickets had caused maldevelopment of their pelves and severe anaemia produced added hazards. These people of Glasgow had suffered much greater poverty and for a much longer period than had the poor people of Northamptonshire. It is often forgotten now, that it was mainly the women who suffered ill health before the introduction of the Health Service, because they could not afford medical care or treatment.

Initially, the five-bedded wards became seven-bedded but the Labour Ward and Premature Baby Facilities also became inadequate and in 1948-50 changes were carried out. A temporary post-natal ward, estimated to last for ten years, was added as an extension from the ground floor. Some fifteen years later this ward was renamed 'Robert Watson Ward' in appreciation of the work of the 'Father of Obstetrics' in Northamptonshire. An additional floor was built to provide bigger and better Labour Wards and the old Labour Ward on the first floor was converted into a Premature Baby Ward. The Nurses' Bungalow was built near to the Extension Ward to provide housing for the pupil-midwives and a classroom. About this time, the Private Patients' Ward was built as a new wing off the green corridor. This released the single rooms at the front of the ground floor to be used for isolation purposes if required.

The new Labour Ward on the second floor was provided at the expense of the very important 'levenses room' and eventually the Isolation Ward was converted for staff dining room facilities. This also solved the problems of staff having to go all the way to the front of the General Hospital for meals in the Staff Dining Room, where they were very unpopular because of their frequent late arrivals.

In the new Labour Wards, to the left of the staircase, a corridor gave access on the left to a first-stage room and a staff cloakroom. At the end on the left was a minute office and also a three-bedded admission room. Progress had dictated that the admission slab should be superseded by a shower but this too failed as it never functioned properly! Initially all except very ill patients had to pass through the routine admission procedure in this room, before progressing to their allotted ward.

On the opposite side of the corridor were two first-stage rooms and a sluice room. To the right of the staircase, at the far end of the corridor, were two delivery rooms on each side. A scrub-up room with sliding doors separated each pair of delivery rooms. Between the delivery rooms on the right and the lift shaft was a sterilising/trolley preparation room – hot water sterilising drums were still used at this time. At the far end between two pairs of delivery rooms were doors leading to a waiting area and the sun parlour which was used as a medical staff office before it was converted into the Special Care Baby Unit.

The Midwifery Training School

The Barratt was approved as a Midwifery Training School in 1938 and Miss Hague was appointed by the Central Midwives' Board as the Approved Teacher. The six months training for pupils was later extended to the two part training scheme, the Barratt becoming the Part I school and the Queen's Institute of District Nursing in Barrack Road becoming the Part II school. Each part extended over a six months period and pupils were required to pass an examination at the end of each part as well as a separate examination for inhalation analgesia. Initially Part II was spent entirely in the district and pupils would deliver and care for some fifty or so

patients in their own homes. Later Part II was divided and pupils spent three months at the Maternity Unit for normal Midwifery at St Edmunds' Hospital and then three months on the district. In 1945 the inhalation analgesia training and examination were incorporated into the main course. Midwifery training continued along these lines until the twelve months single training course was introduced in the mid-1970's.

As well as being in charge of the running of the Barratt Home, Miss Hague was the Midwifery Tutor until she appointed me as her first Tutor in 1951, though she never ceased to seize every opportunity to teach in the practical field. She strongly opposed any separation of the theoretical and practical training – no doubt this was one of the reasons why so many of her pupils enjoyed their training. She did not just teach Midwifery, she made us learn and love the work. In the earlier days, a small room in the General Hospital Nurses' New Home was used as a classroom and it was a great luxury to have a purpose built classroom on site when the pupil-midwives' bungalow was built. Miss Hague used to give voluntary coaching classes most evenings in her flat. The volunteers increased as the examinations drew nearer, though there was always a good attendance even though they did not start until after duty at 8.30pm. She was remarkably adept at teaching the patients and pupils simultaneously. The patients were always regarded as individual people and the most important people in the 'Home' – a title to which she attached great importance. As new pupils we heard that she could 'get a baby to suck off a brick wall' and we did not feel fit to graduate until we could succeed likewise in this skill.

Some teaching was passed on by word of mouth from one set of pupils to the next and I do not think that our technique for remembering the Central Midwives Board rules (39 I think), originated from Miss Hague, for I only remember one; namely 'Thou shalt not tickle they neighbour's os' – in other words 'no unnecessary vaginal examinations should be carried out'!

As well as the six months Part I course, Miss Hague also taught the non-SRN candidates for an 18 months course, very often on a one-to-one basis. Mr Watson and Mr Sturtridge also gave lectures each week and as the training developed, Dr Waddy and Dr Gosset also lectured on their own specialty. They were all good lecturers and often amused us with their anecdotes. To emphasise the importance of the careful recording of urine output for pre-eclamptic patients, Mr Watson would recall an incident when, as a very inexperienced junior doctor in Obstetrics he was instructed, by his consultant, to 'get that patient's kidneys working'. Not having any technical medical knowledge of how to do this, he reverted to his personal experience and ordered a glass of beer three times a day!

Medical Staff

As the work increased, Mr Watson increased his staff to two Housemen and he was assisted, part time, by Mr Gordon Sturtridge, who was then also Medical Superintendent of the whole hospital. In 1947, prior to the introduction of the National Health Service in 1948, Mr Stanley Hill was appointed as the non-medical Administrator to take over the administrative responsibilities and Mr Sturtridge became the second Consultant Obstetrician/Gynaecologist. Miss Sadie Lehane was the senior House Officer from the early 1940's and became Mr Watson's senior Assistant at the Barratt before transferring to Kettering in 1954, where she later became the Consultant for the northern end of the County. Sadly Mr Sturtridge died in 1963 while still in post and Mr Watson became ill and retired in 1965 and died in February 1967. With the ever increasing workload and the declining health of the two consultants, a third consultant, Mr Tony Alment (now Sir Anthony) was appointed and Mr Arthur Bates and Mr AJ van Amerongen were appointed to replace the two consultants. Both Sir Anthony and Mr van Amerongen had held Registrar posts at the Barratt in the mid-1950's.

Written by:

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With special thanks to:

Northampton General Hospital Archive