SOME OF THE ORDINARY DUTIES OF THE OBSTETRICIAN.[1]

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The practical duties of the obstetrician begin with the union of the male and female pronuclei and end only when the process of involution is complete.

It is his to watch over the welfare of the mother and child all through the pregnancy, to take care of all of the accidents or complications which may take place during this important and interesting developmental period; to be present at labor and conduct it with the greatest possible safety to both mother and child, and to direct the treatment of both during the lying-in.

I repeat these are his ordinary duties ,and none can be more sacred or responsible. No branch of medical practice calls for more tact and

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skill, more erudition and profound judgment. This leads me to say that the first duty of the obstetrician is to see that he has an intimate knowledge of his work, not alone that he is conversant with the mechanical skill requisite in the delivery of a woman, but that he has a broad and intelligent acquaintance with all that pertains to his art. In other words, it is his duty to fit himself out as a physician in the fullest sense of that term.

The title obstetrician does, or should, presuppose an educated physician. Theoretically, we cannot conceive of the obstetrician apart from education; nevertheless, one of the dark spots on our civilization is the fact that all around and about us ignorant midwives of both sexes, midwives utterly destitute of a knowledge of the first principles of medicine, are permitted to take charge of, to care for and protect the fair mothers of our land in that critical and trying time, the "period of labor."

After having acquired the called-for preliminary education, the next duty of the obstetrician is to possess himself of all the necessary instruments, drugs and appliances for the successful practice of his art as taught by the best teachers and writers.

He should cause it to be generally understood among his patrons that those wishing to employ him must engage him prior to the expected time of confinement, one of the principal reasons being that he may call upon his patient previous to labor setting in and ascertain the actual condition of her case.

When engaged, he should furnish the party with something like the following card, which I use myself, and which has been adopted by the Pittsburg South Side Physician's Association:

STUB.	OBSTETRIC ENGAGEMENT CARD.
Engaged	*Pittsburg, Nov. 14, 1892.*
Expected	*Mr. John Jones, No. 3848 Carson Street, 40th Ward, has this day engaged me to attend his wife in confinement, which is expected about Dec. 1, 1892.*
Name	
Occupation	
Residence	
Name af wife	*John Milton Duff, M. D.*
Remarks	RULE OF SOUTH SIDE PHYSICIANS.
.....	If the physician engaged cannot be secured at the time he is needed, this card must be presented to any other physician called upon, to warrant his attendance.
....	All cases of midwifery cash.

The card is a protection against "dead beats," and is a guarantee to any physician who may be called in the absence of the expected attendant that the case is a worthy one.

When the preliminary visit is made to the patient the physician should write upon the reverse side of this card the results of his examination; then, if another physician should have to be called in his

absence, he will have the benefit of the knowledge thus imparted. No one should engage positively to attend a woman in her confinement. A proviso should always exist:

"*On making a promise to attend a woman when notified that she shall be in labor, he can be held liable for breach of contract, but not for personal injury and suffering, if, because of his wilful neglect to fulfil his promise, harm comes to the woman.*"—*Hunter and Ogden, 1 Queen's Bench, 132.*

"*On the other hand, he can collect his fee, if, after contracting with a patient to attend her in labor, she without notice and unnecessarily neglect him, by calling in some other physician.*"—*Obstetric and Gynecic Jurisprudence Appendix, Cazeaux and Tarnier, p. 1180.*

In this connection I may just say that if, while in attendance upon a woman, the attendant leaves her and any accident happens her or the child during his absence, he is legally responsible for the results. That while he is responsible for errors of *omission* as well as of *commission*, errors of judgment are not considered malpractice in themselves, where the party has not otherwise offended by negligence or rash experiment.

"If, when attending a case of labor, he for some other reason than danger to his life, leaves the woman before delivery is completed and before the arrival of another physician, he may be held liable for damage if the woman suffer from want of help, and for manslaughter if the patient dies in consequence of this neglect."

Braxton Hicks, *London Lancet*, Aug. 11, 1885: "*A physician was tried for manslaughter on account of having deserted a woman in labor, whom he had been called to attend, because of abusive language employed by the husband toward him. Other medical assistance was obtained after a time, but the labor was a difficult one, the woman subsequently dying of puerperal fever. The physician was acquitted, since it could not be proved that the same result might not have followed had he remained with the patient, but it was strongly laid down by the judge that a medical man should on no account leave a woman in labor except his life was in peril; that he should tell them to get another attendant, and not leave until the arrival of the other; otherwise, should the woman suffer from want of help, he would be held responsible for it.*"

On visiting his patient, the first thing for consideration is the existence of pregnancy. Is the woman pregnant? Her assertion that she is can only be accepted as presumptive evidence. A physical examination revealing the positive signs of pregnancy must be the guide to a decision. If pregnancy exists, a note must be made of the probable time of gestation, the presentation, the position, the external measurements of the pelvis, the number of pregnancy, the history of previous pregnancies if any, the existence of complications, the general health, family history, etc.

Inquiry should then be made with regard to the nurse and instructions given relative to the preparation of the room and bed. Necessary

medicine, a fountain syringe and other effects should be ordered. If the woman does not understand the nature and importance and the manner of procuring asepsis, she should be told in as plain a manner as possible of its importance for her comfort and safety, and directed how to ensure it.

If, in the examination, any diseased condition is present, it should be prescribed for. If the presentation is abnormal, if the time is not too far distant from the expected confinement, it should be rectified. I speak thus advisedly, because I do not think, as a rule, attempts should be made to perform version by the external method at the most more than ten days before the expected oncoming of labor, as otherwise by the manipulations premature labor may be brought about. This first examination will generally satisfy the attendant as to the necessity or not of his seeing his patient again before the onset of labor. He should universally, on going from his office, leave as accurate word as possible with regard to the probable time of his return and where he may be found if needed in haste.

When summoned to attend a woman in labor, he should take with him, or if away from home he should send a messenger at once for his "hand-bag," which should contain all instruments, drugs and appliances necessary, not only in ordinary cases, but as well, such as will meet any sudden emergency which may arise.

The contents of his satchel should at least consist of a pair of forceps, "Hodge, Elliott, Simpson or Wallace," a pair of axis traction forceps, or at least traction rods attachable to his other forceps, a pelvimeter, silk, wire and cat-gut for sutures, needles and holders, Sims' speculum, volcellum forceps, artery forceps, silver catheter, also a gum catheter (No. 7), Barnes' dilators, a hypodermic syringe, morphia tablets or solution, chloroform, ether, Monsel's salt, carbolic acid or creolin, bichloride or bin-iodide of mercury, solution muriate cocaine, a small package of aseptic cotton or lambs' wool, a roll of iodoform or bi-chloride of mercury gauze, $\frac{1}{40}\frac{1}{00}$, the latter for tamponing the uterus in event of severe hemorrhage, and also for dressing the cord. A piece of gum tubing, a yard or more in length, to be used in conducting the urine from the catheter to a vessel, in event it is needed. With the prospect of valuable time being at his disposal, the practitioner should always have about his person a medical journal which may engage his attention with great benefit during his hours of waiting. A very busy practitioner, and one of the best read physicians it has ever been my pleasure to meet, told me it was in this way that he kept himself so intimately acquainted with current medical literature.

When he arrives at the house his first duty is to ascertain if the woman is in labor, and, if so, to see that his instructions with regard to her dress, the preparation of the bed and asepsis have been carried out. Before proceeding to make vaginal examination he should see that the

woman's external genitalia have been washed thoroughly with soap and water and afterward with one of the following solutions: Cupri sulphas 1 to 100, carbolic acid 1 to 40, creolin 1 to 50, bi-chloride or bin-iodide mercury 1 to 1000. He should also see that the bladder and rectum are evacuated. The condition of the patient and her environment must satisfy him as to the necessity of a vaginal injection; as a rule, at least in a private practice, I think this is unnecessary. Where a vaginal injection is thought necessary, I have no hesitancy in saying that a solution of creolin is by far the best. If, however, at any time during labor, it becomes necessary to introduce the fingers or hand into the uterus, such examination should always be preceded by a vaginal douche with one of the solutions just indicated. His own hands should be scrupulously cleaned with soap and water, especial attention being given to the nails. After this they should be washed for several minutes in one or other of the above solutions. He should not touch, after this cleansing process, any object before introducing his fingers into the vagina, neither should he withdraw them and again introduce them without first rinsing them in the antiseptic solution. By this examination he should verify the presentation and position, the condition of the soft parts, the dimensions of the pelvis, the force and character of the pains and approximate the probable duration of labor. The golden rule with him in practice is, in deciding after this examination upon his manner of conducting the labor, to keep out of consideration his own time. He has no moral or professional right to adopt any course simply for his own interest. Everything done must absolutely be considered only in reference to the best interests of the mother and child.

If, in his examination, he has found everything normal, he should so express himself in the hearing of the patient. If, on the other hand, an abnormal condition is found, there is a difference in opinion among the profession as to the course to be pursued. Some say these facts should only be made known to the husband or other immediate friends.

Of course, the character, the physical and mental condition of the patient must be a determining factor in the course to be pursued. My own experience has been that the cases are exceptional in which a candid statement should not be made to the patient, while, at the same time, she is to have an assurance of the attendant's ability to rectify the trouble as best it can be done under the circumstances. The attendant must endeavor to retain the entire confidence of his patient, keep her assured of his sympathy in her pain and of his earnest desire to make her suffering as light as possible. To this end he must be brave yet careful, firm yet tender, truthful yet secretive, watchful and encouraging.

Again, the general reputation of the attendant in the community for veracity must be considered. Deceive a woman as to her condition and he will ever after have difficulty in convincing her of his sincer-

ity, however honest his assertions may be. The nurse, assistants and friends, while, perhaps, recognizing the justice of his prevarications, will ever after fail to have implicit confidence in him. "Truth at all hazards" should be the maxim.

If the examination has shown that the woman is in actual labor, and everything is progressing normally, he assumes the position of watchful expectancy. It will not usually be necessary for him to remain in the lying-in chamber, in fact, it is not always best that he should do so, as his continual presence may have an irritating or depressing effect upon the patient. This is a matter that must be left to the individual judgment of the practitioner in each particular case. If the patient specially requests his presence, her wish should be gratified. After labor has actually set in, the attendant should never go out of easy hailing distance for any length of time. Examinations as to the progress of the labor should be made at intervals of an hour or two, as may be thought necessary. Vaginal examinations should be as rare as possible, if made at all. Before retiring from the room, no difference how reliable the nurse may be, he should see, even to the most minute thing, that everything is in readiness. His instruments and medicines should be placed where they will be within easy reach, some place them on a stand beside the bed. I prefer to put them on a stand in an adjoining room, as their presence beside the patient has not always the most happy effect upon her imagination. Clean linen should be prepared and dried and aired for a change if necessary. A great amount of worry and fatigue at an inopportune time by a change of apparel may generally be avoided by folding the chemise and shirt up around the body of the patient and making a soiling skirt of a folded sheet, which can be pinned around the body and which will absorb the discharges. A binder with pins should be at hand, as also a pair of scissors, a piece of tape or wrapping yarn for tying the cord, a couple of pairs of spring forceps, with which to compress the cord if a hasty section become necessary, a shawl or blanket for the reception of the new-born child. Hot and cold water should be provided for, and ice, if convenient, two basins, one with antiseptic solution, another with soap and water, and several clean towels. One must be ever on his guard to not wound the feelings of the poor by asking for something which their circumstances will not justify and which may only be found in the homes of the opulent. Crudeness, indeed, may be necessary, but this need not militate against cleanliness.

When the patient is able to do so, she should be requested to sit up or walk around the room during the first stage of labor, and sometimes this may be of very great advantage in the first part of the second stage. She should be instructed with regard to the reserving of her physical powers for the expulsive stage, and told that all pulling on hands, sheets and ropes, and labored efforts during the first stage of labor is

only an unnecessary waste of valuable energy. If the woman is still in the first stage of labor, the os rigid, dilatation slow, and the pains severe, there being no positive contra-indication, a hypodermic injection of morphia should be given, thereby mitigating the pain and suffering, and perhaps affording needful slumber and, at the same time, relaxing the tissues of the os so that that they will be more susceptible to the influences of the dilating forces.

When the os is well dilated and the membranes not ruptured, this should be done with great care, lest the sudden gush might bring down a loop of the cord. Delivery should never be allowed to take place without previous rupture of the membranes, lest the placenta be dragged from its attachment and hemorrhage result.

If the os is dilated or dilatable, the uterine contractions strong and productive of great suffering, and the presenting part is not advancing at a commensurate speed, the powers of nature should not be relied upon too much. Overmeddlesome midwifery cannot be too strongly condemned, nature should always be given a fair chance; where she is overtardy and fails to do her full duty promptly, art should at once come energetically to her rescue. This can often be done, the operator having accurate knowledge of the presentation and position of the child and the mechanism of labor, by properly applied pressure or traction to assist flexion, rotation and descent. Sometimes this, in connection with a change of the position of the woman, so that the line of force of the expelling power will be thrown in the direction of the center of the axis of the various planes of the pelvis, will give all needed assistance. If this fails to effect an advance, the forceps should be applied with proper aseptic precautions; the forceps, when rationally applied, are one of "God's best gifts to woman."

I know there are those upon this floor to-night who are ever on the alert to speak disparagingly of the frequent use of forceps. They say they scarcely ever apply them, and that they believe the duty of the obstetrician is to be conservative. I myself believe in conservatism; there are comparatively few men who apply the forceps less frequently in their daily private practice in proportion to the number of deliveries than I do myself. I think there is very often a misapplication of the term conservative, especially in applying it in relation to radicalism in practice.

Those who never apply the forceps are just as absurdly conservative as those who always apply them are absurdly radical. The most radical operation may be the most conservative, or, applying the term *per contra*, the most conservative may be the most radical operation. The conservative practitioner is the preserver. He conducts his case with an eye to the comfort and safety of his patient. His ism is that which will do the greatest good. He is allopathic in the highest, truest, noblest sense.

One of the most important and delicate ordinary duties of the obstetrician is the preservation of the perineum. I do not claim that rupture of the perineum can always be prevented; there are cases in which its preservation is impossible, even in the hands of the most experienced and painstaking practitioners.

I do claim, however, that the percentage may be reduced to a minimum of less than three per cent. in multiparæ and less than nine per cent. in primiparæ, and I am not sure but that, with proper care, it can, by the aid of episiotomy, be reduced to almost *nil*.

There is no special method for its preservation applicable to all cases, each case must be studied of itself, by itself, and for itself. Prof. Lusk says: "Measures to avert rupture may be classified under three headings, viz.:

"*First.* Those designed to check the exit of the head before the fullest expansion has been secured, and to prevent repulsion during the acme of pain, when the borders of the orifice are most rigid.

"*Second.* Measures which impart an upward movement to the head, with a view of making all unoccupied space beneath the arch of the pubes available.

"*Third.* Measures which favor expulsion during the interval between the pains, or at least after the acme has subsided."

Time will not permit to-night for me to attempt to enumerate in detail the different methods applicable to these measures; whatever method is adopted should embrace the following principles, viz.:

First. There must not be any direct pressure on the perineum over the presenting part.

Second. The presenting part must be kept under control, so that its advance can be stopped instantly, if necessary.

Third. There must be gradual advancement of the presenting part and in the direction which will cause the least tension on the soft parts of the mother.

The prophylactic treatment should not be neglected. The training of the perineum, as I practice it, by anointing it with warm lanolin and making gentle traction upon it during the descent through the pelvis, will, if properly and carefully done, more than remunerate for the trouble by the satisfactory results to be derived.

Episiotomy is certainly more desirable than a rupture along the raphe. Great care, however, should be exercised, so as not to perform it unless rupture is positively otherwise unavoidale. Under no circumstances should a false sense of delicacy prevent the exposure of the parts to the full view of the attendant during the expulsion. This, I think, should be the rule of practice, as no tactile sense can ever be as efficient or give that sense of security we have from direct vision, and, furthermore, all of the exposure necessary need not offend the most sensitive.

Immediately after the delivery of the head the nurse should be directed to place her hand, or the attendant himself should place his hand, over the fundus uteri and make gentle pressure, following it down during the contraction. The attendant should immediately upon the delivery of the head wipe the mucus from the eyes and out of the mouth of the child, see that there is no undue tension or pressure on the cord; during the expulsion of the body he should give particular attention to the perineum, as rupture of it very frequently happens, especially during the delivery of the shoulders.

If the presentation happen to be a breech, each part must be covered with a warm towel as it is delivered, in order to avoid the reflex influence of cold in exciting attempts at respiration. The rotation of the body must be directed so as to bring the occiput to the front and delivery hastened as may be indicated by the condition of the fœtal circulation.

If the child does not immediately cry after birth, a gentle smacking on the buttocks, or a little douching of cold water upon the face and thorax, is all that is necessary as a rule to excite the reflexes.

If this does not suffice, the mucus should be drawn from the bronchial tubes by means of the catheter, and artificial respiration, and alternation of hot and cold effusions or baths may be resorted to.

The cord should be tied about two inches and a half from the body of the child, thus obviating any hernial protrusions and leaving room for re-tying if necessary. I think the mummification of the cord is hastened and the danger of sepsis materially diminished if the contents of the cord are expressed toward the placenta before tying. After tying the first ligature, the contents of the cord should be expressed toward the placenta above the point of intended ligation.

This is only intended to prevent any mortifying spurting of blood upon the attendant or over the bed-clothing when the cord is cut. The cord should always be held across the fingers and the cord cut made between the fingers, to obviate the danger of cutting any other part of the child.

Some practitioners do not tie the cord until pulsation has ceased, unless there is something in the condition of mother or child to call for its immediate severance. This is good practice, but not at all necessary when the child is strong and healthy. As previously intimated, sometimes the most hasty section is necessary, in which case a pair of forceps may take the place of the ligature for the time being.

After cutting the cord, the child should be laid on a shawl or blanket and handed to the nurse, never, however, until it is breathing properly.

The attention of the attendant should then be given to the woman. He should first note the contraction of the uterus, the presence or absence of hemorrhage, the condition of the pulse, and in a few minutes,

with slight pressure over the uterus and gentle traction upon the cord, deliver the placenta. The placenta should always be twisted during its delivery so as to gather all portions of the membranes, a small portion of which, if left in the uterus, may lead to a very serious if not fatal complication.

As the delivery of a retained or adherent placenta may be considdered among the extraordinary duties, and more especially as time will not permit, we will not dwell farther upon the third stage of labor.

The external genitalia should now be cleansed, the parts exposed and lacerations looked for. If any be found, it is scarcely necessary for me to argue at this day that unless there is the most positive contraïndications, which is very rare, they should be immediately closed by suturing.

The soiled clothing should be removed and replaced with clean. A binder may or may not be placed around the woman, according to the wish of the patient or the doctor. They sometimes add to the comfort of the woman, and where hemorrhage is feared it helps to irritate the uterus to contraction.

It is a power for evil, however, if not properly applied. It should extend below the trochanters and above the umbilicus, and should only be drawn to give a gentle, firm, equable pressure over the abdomen.

An aseptic soiling cloth then being placed against the vulva, the woman should be covered up and allowed to rest quietly in bed.

I have not placed among the ordinary duties the syringing of the vagina or of the uterus after delivery. Where the hand has not been introduced into either of the organs, especially in private practice, I do not consider it essential.

After attending to the woman, attention should be given to the child. Its whole body should be well cleansed with lard or vaseline, its eyes and mouth washed with a little tepid water. I do not think the body of the child should be washed with water until the second dressing.

The child should be carefully examined for tongue tie, imperforate anus, or meatus urinarius, and for other abnormalities, and if any are found, when politic, immediate operation performed.

The cord should be dressed aseptically. For this purpose a fold of iodoform or bichloride of mercury (1 to 4000) gauze, with an incision in the center through which the cord is to be drawn, is placed around the cord, which is then well wrapped in some antiseptic cotton or wool and a binder applied.

I regard this dressing of the cord as of paramount importance, and wish especially to call attention to the fact, well authenticated, that a septic cord is not infrequently the cause of the death or sickness of the mother or child or perhaps both.

In one hour after delivery, if the mother is in fair condition, the attendant may depart. Not without first taking the temperature and

pulse of the patient, ascertaining that the uterus is well contracted and that there is no hemorrhage; not without interdicting the visits of friends for congratulations and to enforce quiet.

The nurse should be cautioned strictly against touching the genitalia without first rendering her hands aseptic. Medicine should always be ordered to be given in the event of the oncoming of severe after pains.

At his subsequent visits, the first of which should be within twelve hours, and in no case later than twenty-four hours, a careful examination of both mother and child should be made, and in no case should he ever forget to satisfy himself that the woman has not retention of urine.

To this end, never accept the word of the patient or nurse that the urine has been passed. Insist either upon knowing the quantity or of having it saved for inspection.

This rule cannot be too energetically impressed upon the young practitioner. Any other course will almost certainly, sooner or later, bring about an ignominious disaster which will impress its importance upon him as if by fire.

Special directions should always be given with reference to the care of the breasts and nipples so as to prevent chafing, fissures or abscess. Nurse and mother should be impressed with the fact that infants form habits very readily, and, therefore, the need of regular hours being assigned it for food and sleep. When the cord drops off, the physician should give personal attention to the umbilicus, and, before finally discontinuing his visits, he should note the degree of involution of the uterus. It is well to see and examine the position and size of the uterus about the fortieth day.

A rule should be absolute that under no circumstances should the woman leave her bed and room finally before the fourteenth day after delivery. Last but least, having performed the work conscientiously, it is a duty to make a charge commensurate with the work performed.