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THE FADS AND FANCIES OF OBSTETRICS. A COMMENT ON THE PSEUDOSCIENTIFIC TREND OF MODERN OBSTETRICS*

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IT IS useful, now and then, to look backward, for an occasion may arise when necessity will demand that we shall retrace our steps, or at least that we may measure our progress. Without retrospect we may lose the proportion of things and awake to the fact that we have made no advance, in fact have merely run around a vicious circle. We all know how phenomenal have been the advances in obstetrics in many particulars; untold benefits have come from the introduction of anesthesia and asepsis which have made possible many operative procedures which were the dream of the obstetricians of the past. Under the new regime the indications, at first, were clearly and definitely drawn; as the certitude of the freedom from pain from anesthesia and the proximate eradication of sepsis were realized, indications were placed on a broader basis, until they became so loosely laid down that they had no real justification beyond what the operator determined for himself. It is not far from the fact that obstetrics, today, is in identically the position that oöphorectomy held some twenty-five years ago. The indiscriminate employment of operative intervention in obstetrics has accomplished little in the way of conservation of life of the mother and child; in fact, as I see it, conservation of life is not to be realized

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ing operations on the mother—which now more euphoneously are denominated obstetric surgery.

The fact that modern maternity hospitals, where is centered the obstetric skill and knowledge of our profession, have been unable to decrease the dangers of birth to mother and child over the figures obtaining the early part of the nineteenth century is *prima facia* evidence that modern obstetric surgery is ineffectual in combating those dangers. Table I has been prepared to demonstrate this contention. The fluctuations in the maternal death rates, before 1880, ranged from 0.44 to 1.28 per cent, and are only variants which would come to any institution from year to year. Since 1910 the rate varied from 0.41 to 1.01 per cent in different institutions. An analysis of the children was not so graphic in view of the fact that some writers, as Moran, combined abortions and stillbirths, others included stillbirths and those dying in the hospital. Still, the figures show how little progress has been made these many years. There are many arguments which might be advanced to show why present hospital statistics are not comparable to those of olden times—the main one being that *now* it is customary to send women with complicated labors to an institution which largely, in the former period, were treated at home. Harrar[10] shows this graphically in his report on the deaths in the New York Lying-in. How much is offset by the tendency to treat those complications by surgery rather than by obstetric methods is debatable.

Two complications of pregnancy may be briefly discussed to show how negligible has been the advance in recent methods of treatment. Eclampsia stands out preeminently as a complication which demanded some method of delivery ever since Blundell,[1] in 1834, discussed the advisability of acceleration of delivery, and Carl Braun[9] popularized it. During last twenty years various obstetricians have improvised operative measures which might accomplish the result with a minimal lapse of time. More discussion has been employed on how to empty the uterus in eclampsia than has been expended on all other phases of the problem. The most evident thing about the question is the paucity of evidence adduced which might elucidate the cause, and then develop a rational therapy. Surgery for eclampsia as the essential part of the treatment is clearly and definitely indefensible. If there be anything to Stroganoff's treatment, it shows most positively that eclampsia is a disease, as popularly treated, which carries a dual mortality—that incident to the toxemia and an equal hazard from the surgical intervention. In Table III, I show that in the preantiseptic days the maternal and fetal mortalities were respectively 20.4 and 33.3 per cent: the modern methods exhibited mortalities of 19 and 39.6 per cent: while in cesarean section in the period covered by modern treatment, the deaths were 34.8 and 25.9 per cent, respectively. Our modern con-

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ception of the treatment considers many things other than prompt delivery: really, it was not until 1850 that remedial agents were advocated other than blood letting, and purging. Blundell[1] did discuss, as did others, the use of opium, but many years elapsed before sedatives, anesthetics, etc., became established adjuvants to the therapy. It may be said that the older authorities had no real therapy, yet their results were as good, even better, than ours. In other words, no modern therapy has modified the lethal progress of mother and child with the single exception of that of Stroganoff: a comparison between the results of the latter with the much lauded cesarean operation shows that approximately one baby is saved at the expense of nearly four mothers. I believe Peterson did an unwise thing in his cesarean-eclampsia papers when he attempted to show how many babies might be saved by the operation, and not showing how many were destroyed by the disease; there is a great difference. Eclampsia always has been a fulminating, acute, malady with a high death rate: the operative measures so popularized are carried out on bad surgical risks. Anuria, bowel stasis, anhidrosis, with marked cerebrospinal manifestations, characterize the disease and, as a result, women have died from the toxemia and the operation: likewise, the infants succumbed to the intoxication and the hazards of a forced delivery. Newell[2] has given ample evidence of the pernicious influence of the teaching that eclampsia demands major surgery.

Mueller[3] stated that one half of the deaths from placenta previa were due to infection. The mortality of the mother has decreased one half by cleanliness, not from an improvement of technic, or startling innovation in treatment. Obstetric treatment has not affected the fetal mortality whatsoever, though cesarean section has reduced the percentage from 55.5 to 35.6. Again, the section has not diminished the maternal mortality over approved obstetric methods and, comparing the results of the average cesarean mortality with the findings of such experts as Stratz,[4] Welti-Pinard,[5] and Koblanck,[6] who demonstrate the gifts of skill, we still find that the section kills women in order that babies may be born alive. *A priori*, it would seem that a previa should only be handled by surgery when the woman is a good surgical risk, free from possible contamination, at or near term, the baby definitely alive, and some valid contributory necessity such as a minor pelvic deformity. The advocacy of a routine cesarean for all previas will bring upon the public malign results similar to those depicted by Newell for eclampsia.

I think the facts I have outlined for those two great obstetric complications are sufficiently alarming to warrant your attention. If a comprehensive comparative study were extended to cover a multitude of ordinary accidents of childbirth I am sure data would be presented

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the solution it certainly would have it to ward off the evil. The crux of the problem lies within the education of the profession and there is no need of an endeavor to place the onus upon the ignorant public.

The rise and fall of the efficiency in judgment of the general practitioners in their obstetric work are reflections of the attitude and efficiency of the obstetric teachers: and by teachers I mean not only pedagogic members of college faculties, but also contributors to current medical literature. The former and the latter may be one, but from the fact that one may be a professor in an approved medical school gives added dignity and weight to his utterances, and therefore, will be more dangerous from that fact if his teaching be faulty. With a few possible exceptions, probably the quality of the teaching of our colleges is as defective as Williams[8] found it some years ago. A few maternities have expanded since Williams prepared his paper: largely, they are still inadequately equipped, with insufficient capacity for proper teaching, or for developing the clinic experience of the teachers themselves. What may one expect of the average teaching force other than it will give inadequate and faulty instruction: that its mediocrity in experience and capabilities will be reflected in the mediocrity of thought and attainment and ability on the part of the students faultily trained. Too often teachers do not instill into their students the breath of conservatism, of sound thinking, of deductive reasoning, so later, as physicians, they grasp at the most nonsensical recommendations. We all can recall our student days when the professor who gave spectacular clinics was more popular than he who conducted his clinic without ostentation: in many of our principal colleges the obstetric clinic of the present is too largely the pyrotechnic exhibition which characterized the older surgical arena. An aggregation of complex, unusual problems are presented, leaving scant time for the ordinary run of obstetrics, such as will be indispensable to the student as a practitioner. Certainly a clinic which gives a student 18 major obstetric operations in his two weeks' practical training has misappropriated the student's time. The modern trend in obstetric teaching interferes with a student's perspective: a student who sees an array of heroic surgery out of all proportion to his practical clinic and didactic work, is so befuddled that he naturally conceives that nearly all cases need intervention. Then again, the student's perspicacity may discern that the professor's indications are weak—but later, as a physician, he will do likewise, backed by eminent authority.

The contributions to the literature are the postgraduate instruction of men in active practice. The authors are the bell-wethers of those who read and learn: these writings may be the guides to the thoughtful to a better understanding, and to a more perfect solution of the difficulties which constantly arise in practice or they may be merely

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TABLE III

ECLAMPSIA MORTALITIES

REFERENCES	PERIOD	NO. MOTHERS	DIED	%	NO. CHILD	DIED	%
Ramsbotham: Murphy Mid.	1840	43	3	6.9	53	18	33.9
Collins, R.: 1862 p. 698.	1835	30	5	16.6	32	18	56.2
Hardy and M'Clintock: Ibid.	1857	13	3	23.	13	6	46.1
Sinclair and Johnson: Ibid.	1847	63	13	20.6	69	23	33.3
Mme. LaChapelle: Ibid.	1821	8	?	?	8	2	25.
Arneth: Ibid.	1849	13	4	30.7	13	6	46.1
Braun, C.: Gyne., p. 833, 1881.	1878	73	20	26.	73	15	20.5
Totals: Before antiseptic era.		235	48	20.4	261	88	33.3
Modified Expectant Methods							
Dührssen: Eclampsia; Winckel's Handb. d. Geb., ii Tl. 3.		80	30	37.5	80	60	75.
Friedman, B.: Ibid., p. 2411.							
Goedecke: Ibid., p. 2412.		403	69	17.1	403	194	48.
Franz: Ibid., p. 2421.		17	2	11.8	17	5	29.4
Sommer: Ibid., p. 2421.		16	6	37.5	16	10	62.5
Jardine: Ibid., p. 2423.		22	6	27.7	23	13	56.3
Sturmer: Ibid., p. 2423.		43	5	12.2	?	?	
Mangiagalli: Ibid., p. 2423.		18	1	5.5	?	?	
Stroganoff: Ctb. f. Gyn., 1910, p. 756.		400	26	6.6	360	77	21.6
Lichtenstein: Arch. f. Gyn., 1911, p. 183.		400	74	18.5	371	144	38.8
Hammerschlag: Op. Gyn., p. 433. From R. Peterson, Am. Jour. Obst., 1911, lxiv, p. 1.		8	3	39.	?	?	
Bumm-Liepman: Ibid.		90	28	31.1			
Esch (1904-5): Ibid.		79	20	28.8			
Esch (1905-6): Ibid.		145	42	28.9			
Glocker: Ibid.		9	3	33.3			
Möhlmann: Ibid.		10	1	10.			
Winter: Ibid.		8	3	37.5			
Zweifel: Ibid.		49	16	32.6			
Totals: Modified expectant cases.		1795	335	19.	1270	503	39.6
Peterson, R.: Am. Jour. Obst., 1911, lxiv, 9.		530	124	23.4	315*	67	21.2
Vaginal Cesarean.					530†	282	53.3
Peterson, R.: Ibid., 1914, lxix, 924.		500	174	34.8	381*	25	6.5
					481†	125.	25.9
Cases before 1908.		198	95	47.9	133*	16	12.
					198†	81	53.3
Cases after 1908, to 1913.		283	73	25.8	248*	9	3.6
					283†	44	15.5

*Results obtained by eliminating children weighing 2000 gm. or those up to eighth month of pregnancy or that were judged to be premature, living or dead: no child was counted which was known to be dead at time of operation.

†We are dealing with a disease having a high mortality, influenced by various treatments, not the dangers of a major operation: i.e., for the sake of comparison it is necessary to add such figures to the infant mortality as will account for the babies not included in Peterson's statistical report.

Maternal mortality has not been ameliorated these one hundred years. Fetal mortality has not been diminished, either. Cesarean section robs the fetus of many of the lethal stresses of forced delivery, therefore Cesarean section saves babies at the expense of the mother.

the occasions for commercializing the writer, who does not exhibit a celerity of judgment in his recommendations. Unfortunately, too often readers are unable to differentiate between the gold and the dross and as a result any one who will report an operation or a line of

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treatment, necessary or unnecessary as it may be, for some ordinary or extraordinary indication, will have imitators who pass the bounds of reason. It may be difficult for the average reader to discriminate between fallacy and truth in the writings of a subtle author: for that reason a man of judgment will not rush to print until long, mature experience justifies the exposition of his theme. There have been too many unwise exploitations which were precipitated upon the profession in the hopes, if they proved popular, priority might be claimed. We all recall the fiasco of twilight sleep furor. We all know the dangerous results which came from the thoughtless laudation of the reputed harmless virtues of pituitrin. The pen is reputed to be mightier than the sword, and it surely is more deadly when wielded by the sophisticated writer.

The basic error has crept into the obstetric field that pregnancy and labor are pathologic entities, that childbearing is a disease, a surgical malady which must be terminated by some spectacular procedure. There is too insistent preachment by those who are defending a reign of terror, of promiscuous operative furor, by the argument that women have so degenerated that childbearing is a phase of pathologic anatomy. These discussions have gone so far that practitioners, supported by spurious authority, are operatively interfering when conditions demand a watchful expectancy, or at most some minor intervention—the culpability lies not with the general practitioners, but their sponsors. And no one is doing so much of this needless operative interference as many of our reputed leaders, and they know not the wreck they have wrought, for they hear only the encomiums on their fallacious representations and their misapplied skill. Those who have stopped, looked, and listened have seen and heard the catastrophies which have accumulated in the wake of the false promulgations. I believe there should be a most emphatic declaration that childbearing is *not* a disease, is a normal physiologic function which may develop pathologic aspects and for that reason all women should have a most careful conscientious prematernal care so they may guard themselves and be protected against possible disaster to themselves and their offspring. The general polemic that labor is a species of the torture of the inquisition has been advanced so frequently that many defend most drastic interferences on the score of saving women this horror—that the dread on the part of women of this frightful agony warrants any and all kinds of expedients to relieve them of the various stages of labor, when, in fact, too often these strictures are merely the shibboleths of those who would operate with little or no provocation. In consequence, we see some who claim the great object is to shorten the first stage by the routine introduction of the bag; another, that it is an obstetric crime to interfere with the delicate mechanism of dilatation, but the moment

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dilatation is completed, then, the parturient canal must be slashed, and the baby and placenta delivered by high art. Another holds that the baby must be ushered into the world as custom dictates it shall make its mortal exit—feet first; again, we find men who believe the cesarean operation the panacea for all ills and make it a routine procedure. I have been credibly informed that for a woman to be more than six hours in labor brought censure or reproach upon the physician in attendance, in one of the large towns contiguous to Boston. A former student was showing me through a hospital where he was resident: he informed me he was told, as a joke, that the "office hours" was the principal indication for forceps, but when he got on the obstetric service he found it was the plain truth. I have yet to be convinced that the average woman is repressing the reproductive function from the fear of the pangs of labor: the woman who is so loath to assume motherhood on this score probably has such an absence of maternal instinct that her progeny, uncreated, are more happily situated in the *here-to-fore* than made subject to her selfish influence. Those who have studied the situation know full well that sociologic-economic necessity transcends all others in the restriction of families.

In the past, conservative writers arraigned those who did meddlesome midwifery, the vogue of the times being minor transgressions like protracted digital dilatation which accomplished no purpose, titillation of the clitoris for the purpose of exciting pains, or making the hapless woman forget her troubles, pulling on the cord, or too frequent application of the forceps, etc. Meddlesome midwifery has now taken a more serious turn until it comprises all the known methods of necessity, even major surgery, without the vital essence of a valid indication: the favorite rôle being those which will consummate delivery with the minimal expenditure of time. Is it not a parody on modern scientific obstetrics that each advocate of his special form of interference will proclaim results not in consonance with the experience of experts, will declare the simplicity of the procedure is such that all may do it, no untoward effects need be expected, when in our hearts we know their allegations, probably based upon thoughtless enthusiasm, are most egregiously exaggerated? And when these advocates appear before a scientific body, with their spacious claims, all laud their skill, and rarely is one courageous enough to combat the irrational and untenable interference.

It was a natural consequence that all obstetric procedures had their indications widened as their relative safety became established. But that any operation, because asepsis makes it reasonably safe and anesthesia keeps the patient quiet during its performance, should be so inordinately broadened in its scope that the suspicion (no candid admission) is evidenced that it is being done for the convenience and con-

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TABLE IV

TREATMENT OF PLACENTA PREVIA
MORTALITIES COMPARED

OBSTETRIC TREATMENT TABULATED BY HOLMES	MOTHERS NO.	DIED	%	CHILDREN NO.	DIED	%
Ramsbotham*	82	?	?	82	50	60.9
Collins*	11	2	18.1	11	5	45.4
Hardy and M'Clintock*	8	3	37.5	8	3	37.5
Sinclair and Johnson*	24	6	25.	24	13	54.1
Arneth*	9	1	11.1	9	6	66.6
Braun, C.†	37	9	24.3	37	18	48.6
Klein*	11	2	22.2	12	12	100.0
	100	23	23.	183	107	58.4
Read, Wm.: Placenta Previa, 1861, 12 tables.	978	206	21.2	850	447	50.8
††Blacker: all since 1880	22	1	4.5	22	8	36.3
Kouwer	8	3	37.5	8	3	37.5
Ribbius	98	7	7.1	98	39	40.8
Stratz	57	1	1.7	57	36	63.
Fry	14	0	0	14	5	35.7
Galabin	92	15	16.1	92	69	75.
Hautel	123	12	9.7	123	92	74.1
Hirst	28	0	0	28	24	50
Siebert	24	10	16.8	24	8	33.3
Dorman	84	10	11.9	84	38	45.
Welti-Pinard	149	4	2.6	149	34	32.7
Lomer	236	21	8.9	178	105	60
Drejer	49	2	4.09	50	12	23.5
Platzer	46	4	8.7	46	25	53.2
Zedler	16	2	12.5	16	6	37.5
Higgins	75	8	10.6	?	?	
Rotunda Hospital	74	3	4.	?	?	
Murphy	61	2	3.2	?	?	
Klein	138	13	9.4	?	?	
Schauta	234	16	6.8	234	127	54.
Strassmann	231	22	9.5	231	144	61.2
Driessen	125	19	15.2	125	80	64.
Doranth	216	20	9.3	216	152	70.3
Fournier	7	0	0	7	3	43.
Koblanck	467	18	3.8	?	?	
DeLee	30	1	3.3	31	13	41.9
Amadi et Ferri	100	5	5.	100	32	32.
Behm	52	0	0	52	30	60.
Totals.	2756	213	7.4	1985	1075	54.1
Jewett: Am. Jour. Obst.	2010	221	10.9	2020	1159	57.3
Behm, omitted, repeated	40	0		40	31	
	4726	434	9.2	3965	2201	55.5
Abdominal Cesareans.						
††Cases collected by Holmes: also 7 babies	25	5	20.	25	9	36.
died within 14 days.					16	64.
Jewett: Am. J. Obs., p. 943, June, 1909.	95	11	11.5	97	37	34.
Davis, Asa, Am. J. Obs., p. 120, Jan. 1915.	21	2	9.5	21	7	33.3
Davis, E. P., Penn. M. J., p. 292, Jan., 1915.	18	0	0	18	7	37.7
Foulkrod: Am. J. Obs., p. 459, Mar. 1913.	4	1	25.	4	1	25.
Doederlein: Cent. f. Gyn. p. 1383, No. 38, 1913.	146	12	8.9	146	44	30.1
Total Cesareans	309	31	10.	311	111	35.6
Obstetric Treat.	4726	434	9.2	3965	2201	55.5
Preantiseptic Period.	1078	229	21.2	1033	554	53.6

*Murphy: Midwifery, 1862, p. 698, et seq.
†Braun, C.: Gynecology, 1881, p. 561.
††Blacker et seq. to Behm taken from table in "Cesarean Section an Improper Procedure," Jour. Am. Med. Assn., May 20, 1905.

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servation of time of the operator, is a travesty on scientific endeavor. I feel that the modern trend of obstetric practice has been to apply surgical manipulation to normality to a degree which is not in consonance with refinement of judgment. What is needed is a reformation in the rules and the development of an obstetric conscience which will permit intervention only when intervention is imperatively needed. Strict indication is one thing, but the widespread use of operative interference with no indication except the whim, or plain obcecation of the attendant, has spelt disaster, has retarded the progress of obstetrics, and has fended off the days of conservation of the expectant mother and her unborn child. It is a reproach on the medical profession that a city like Newark may advertise the fact that it is safer to be delivered by a midwife than by a physician or in a hospital.

CONCLUSIONS

1. In safe conservative hands maternal and fetal mortalities have decreased in private practice.

2. The maternal and fetal death rates, in hospitals, have not shown an appreciable decline in one hundred years.

3. The fact that the death rate among the emergency cases (i.e., those sent in by medical attendants) is over ten times that of regular applicants in the New York Lying-in Hospital is a reflection on the preliminary medical training of the profession.

4. Scientific investigation of antenatal pathology which will promote a prophylactic therapy will lower infant mortalities more than the present attempts to do so by routine operative termination of labor.

5. A properly conducted prenatal clinic, combined with conservative conduct of labor is a more certain method for securing declining death rates than promiscuous intervention.

6. Under normal conditions, spontaneous labor, aided by proper analgesia, is the safest way for mother and child. Inordinately applied operative interferences increase the hazards of birth.

7. The authorities who have fostered a peculiar method of routine interference in all parturient women, with their imitators, have retarded the advance in obstetric care, and are part contributors to the high American mortalities incident to childbirth.

8. It is a lamentable thing that properly controlled midwives will have less mortality than those who practice a routine intervention.

9. The proponents of operative cults have produced no evidence to show that their systems are more worthy, less risky, and promise a higher conservation of life than carefully watched spontaneous labor.

10. There are no more reasons why all parturient women should be delivered by operation than that all people should be inflicted with routine enemata or catheterization.

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11. A medical fad should be discountenanced: precept and example founded on injudicious enthusiasm lead to many unwise courses.

12. Indications for obstetric operations demand revision: certainly, they should be more clearly drawn and curtailed, rather than extended.

13. A wise conservation in obstetrics will be more productive of ideal results than injudiciously used skill.

14. Obstetric teaching is so deficient in most colleges that there should be a sharp and early improvement: so long as obstetric teaching is defective so long will obstetric results be bad in practice.

15. An obstetric curriculum should be devoted to practical instruction on the mannikin, in the class room, and in the clinic; obstetric surgery should be a very small part of the coordinated whole. The proper place of the latter is in postgraduate courses intended for those preparing for the specialty.

REFERENCES

(1) *Blundell*: Obstetrics, 1834, p. 657. (1a.) Ibid., p. 652. (2) Jour. Am. Med. Assn., Feb. 24, 1917. (3) *Mueller, L.*: Placenta Previa, 1877, p. 195, et seq. (4) *Stratz*: Centralbl. f. Gynäk., 1899. (5) Corr. Blatt f. Schweizer Aerzte, 1896, p. 498. (6) *Koblanck*: Encyclopedia f. Geb. u. Gynäk., 1900, p. 189. (7) Jour. Am. Med. Assn., April 28, 1917, p. 1266. (8) Jour. Am. Med. Assn., Jan. 6, 1912. (9) *Braun, C.*: Gynaekologie, 1881, p. 837.

414 Arlington Place. (*For discussion, see p. 297.*)

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Society Transactions

AMERICAN GYNECOLOGICAL SOCIETY. FORTY-SIXTH ANNUAL MEETING HELD IN SWAMPSCOTT, MASS., JUNE 2, 3, AND 4, 1921

THE PRESIDENT, DR. WALTER W. CHIPMAN, OF MONTREAL, IN THE CHAIR

Symposium: To What Extent Should Delivery be Hastened or Assisted by Operative Interference

DR. RUDOLPH W. HOLMES, of Chicago, read a paper entitled **Fads and Fancies. A Comment on the Pseudo-Scientific Trend of Modern Obstetrics.** (For original article see page 225.)

DR. JOHN OSBORN POLAK, of Brooklyn, read a paper entitled **Forced Labor,—Its Status.** (For original article see page 237.)

DR. BROOKE M. ANSPACH, of Philadelphia, read a paper entitled **The Drudgery of Obstetrics, with Some Suggestions for Relief.** (For original article see page 245.)

DISCUSSION OF SYMPOSIUM

DR. IRVING W. POTTER, BUFFALO, NEW YORK (by invitation).—I appreciate your invitation to open this discussion. I have been very much gratified at the papers and very much entertained by the statistics. I am not sorry that I read my first, second and third papers on version, for I can see a considerable change in the expressions of opinion from observers in different sections of the country, and I am going to continue to read papers on version and to do the operation. I am striving all the time to reduce my fetal mortality since the presentation of my first paper. I have had better results since. I am sure that I will get still better results and so will every one who does intelligent elective version.

Our conditions at home are somewhat different from those that most of you have. We have no large hospital where we can take all of our cases. There is not a hospital in Buffalo that will give me the number of beds I want, consequently I am working in five or six different institutions. That in itself will raise the fetal mortality, will raise morbidity, but things are gradually getting better, and it is gratifying to me to find that men from different parts of the country, after they come to Buffalo and see me at work, have changed their views in reference to my work from those they held five years ago.

It seems to me, that the discussion of these papers must be largely upon the following questions, first, whether or not we have any right to interfere in the progress of a case of labor, whereby we may in any way shorten the duration of that labor in the interests of the mother, to relieve her of her suffering and pain as well as the damage to her soft parts from prolonged pressure, and secondly, in the interests of the child, in relieving pressure both cranial and body. Have

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perhaps disgrace to have introduced, there are present before me a certain number (how many I cannot tell) who are doing prophylactic forceps right along. Some of them have acknowledged it to me. That is not to their discredit; I consider it to their credit. We must, as Dr. Polak points out, prove that this interference in labor brings good results, and that in course of time we will probably be able to do.

The time has come, and for some of us has long passed, for a division in the methods of treatment of natural delivery into that by the specialist and that by the general practitioner. The women are beginning to realize that they need not suffer the damage of labor, the permanent invalidism and death that their mothers suffered. They have learned to seek expert skill and they are willing to pay for it. Further, they are not willing to suffer the pain of labor, and demand its relief.

Many women are ready to undergo the slightly increased risk of cesarean section in order to avoid the perils and pain of even ordinary labor. I am confident that if the women were given only a little encouragement in this direction, the demand for cesarean section would be overwhelming.

A careful study of one's own cases will show that even natural labor can cause much damage. The damage is mainly in the cervix, the pericervical tissues, the pelvic fascia and the pelvic floor. It is unnecessary to enumerate the many sequelae of these injuries. We cannot deny their frequency and their rôle in the causation of permanent invalidism. In the last two years I have paid particular attention to these damages. One in five mothers has good closure; four have tears or relaxation, though there need not be bad symptoms at present. These come later. With few exceptions, all women show evidence of anatomic damage.

We know that too many babies die in labor, even in natural deliveries, yet when last year I presented a simple and harmless method for saving a percentage of these babies, several of our members criticized the method unfavorably.

Last year I read a paper called "Prophylactic Forceps." In the discussion, our guest, Dr. Eden, of London, condemned the operation. On the same day Dr. Eden complained bitterly of the high mortality of the neonati of his clinic and the large number of stillbirths. Fifty healthy babies, he said, had died in spontaneous normal labor in the hands of his own expert assistants, and he thought something ought to be done about it. I, too, think something ought to have been done about it, and I wonder how many of these full term, healthy babies might have been saved by the prophylactic forceps operation. If I may be permitted to hazard a guess, I would say perhaps 40 of them. However, it was a great concession by Dr. Eden, to admit that normal labor could kill babies, and I am also wondering how he can escape the conviction that natural labor is pathogenic.

I claim that the powers of natural labor are dangerous and destructive in many instances to both mother and child, and that interference by a skilled accoucheur at the proper time can prevent a goodly portion of this danger and much of this destruction.

It will need a high degree of obstetric skill to determine when interference is less dangerous than Nature's own methods, and to render the interference less dangerous, but the first is what we specialists are for, and the second, is what we are being paid to do. There is no question that in unskilled hands, many things that we can do with safety, will prove dangerous and fatal, but this is no reason why we should not do them.

We must not pull obstetrics down to the level of the practice of the general practitioner. We must pull the latter up to our level.

As to one method of interference in natural labor, I can refer to my paper of last year, the prophylactic forceps operation. The objects of this procedure are: 1. To save the pelvic floor and fasciæ from destruction. 2. To save the woman from exhaustion and hemorrhage, even moderate bleeding. 3. To save the child from

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DR. N. SPROAT HEANEY, CHICAGO.—I take it that we, the audience, are to be the judges in this presentation of briefs, and since the evidence does not all seem to be at hand, I wish to ask for information.

The advocate of one procedure says that the cervix should not be interfered with in any way during the natural process of its dilatation and places all the importance upon the avoidance of laceration of the pelvic floor. Why is the pelvic floor so important while the cervix is unimportant as far as its injuries are concerned, and why should a method be elaborated which concentrates on the pelvic floor and disregards the cervix? If the spontaneous dilatation of the cervix is not dangerous, why is the spontaneous dilatation of the vagina and perineum so full of danger? Dr. Polak has given us some beautiful results to study and I think that we should be interested in the immediate results of labor and until they are impossible of improvement, we should not worry about the late results. A low child mortality is the real criterion as to the superiority of one method of delivery over another, provided the maternal mortality is the same in both instances. Another peculiarity in Dr. De Lee's presentation that I cannot understand is, that he elaborates upon the dangers of the caput succedaneum to the child and says that he avoids this with prophylactic forceps. The question is, since he never interferes with the first stage of labor, whether or not a caput succedaneum only forms in the second stage of labor. We know that it does not, since who among us has not seen a caput succedaneum on children born by cesarean section? This argument then will have to be discarded.

DR. HUGO EHRENFEST, ST. LOUIS, MISSOURI.—Dr. Davis has referred to a fact which is important in this discussion. He would like to have the neurologist testify as to the damage done by forceps extraction.

The neurologist indeed is the one who wants the baby extracted quickly because long-continued compression of the head in his belief is disadvantageous to the later physical and mental development of the child. Unfortunately the obstetrician has accepted this opinion, though as a matter of fact it positively is incorrect. It is based solely on statistics collected in institutions for the feebleminded and insane asylums, by asking the mother of such a feebleminded child whether she had a forceps operation, or whether she had a hard labor. Babies, stillborn after forceps delivery, obviously are not counted at all, and by simply taking the mother's word for it, the large number of those who had a hard labor is not surprising. Actual evidence now available proves beyond any doubt that intracranial damage is due rather to quick compression, to quick and excessive molding than to continued compression. This evidence has been supplied by obstetricians who have followed up their own cases and have compared end results with the exact history of the labor ten to fourteen years ago. Such investigations proved beyond any doubt that all procedures which hasten the passage of the child, and which cause quick and excessive molding, such as the use of pituitrin, of forceps or breech extractions, are more likely to be responsible for intracranial injuries manifesting themselves only later in life than merely a long labor.

DR. CARL HENRY DAVIS, MILWAUKEE, WISCONSIN.—As it has a definite relation to this obstetric symposium, I wish to report the results of a recent questionnaire sent to twenty members of this Society.

Last winter a surgical colleague asked me to examine his wife, a para ii, who had been delivered of her first baby by cesarean section because of a central placenta previa. She wished to go through a normal labor. He wished to know if this were safe since she has a normal pelvis. I went over the situation with the husband as regards the probabilities in the case, and gave him the results of my study of the literature. In addition, I sent a questionnaire to twenty members of the Society, stating briefly the facts and outlining a possible plan of management.

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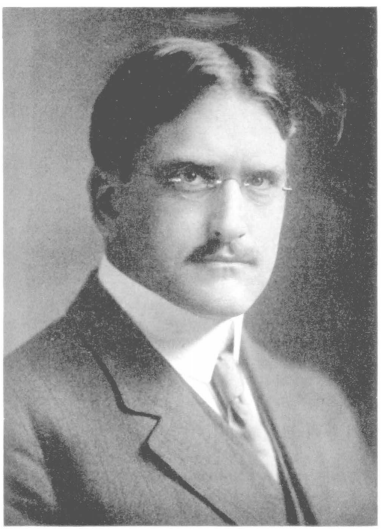

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