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RECENT ADVANCES IN OUR KNOWLEDGE OF OBSTETRICS AND THEIR BEARING ON OBSTETRICS AS A SPECIALTY

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AVAILABLE data on maternal mortality and morbidity in obstetrics not only show slight improvement in recent years, but reveal the fact that when we put our statistics beside those of other highly civilized countries, we occupy a position near the foot of the list. This of course, does not demonstrate conclusively that we are not improving our obstetric art.

Could similarly accurate criteria be presented for late maternal invalidism, for injuries to the child at birth, for craniotomies and embryotomies, for decrease in the number of stillbirths, etc., we should unquestionably be able to show marked improvement.

In the larger medical centers more careful supervision of pregnancy has definitely reduced the incidence of eclampsia. The fact is, that in recent years attention has been focused on the baby and its welfare more than on that of the woman. Moreover, recent improvements on behalf of the mother have been directed toward the prevention of morbidity, rather than toward the reduction of mortality. The prevention of eclampsia, of course, improves the figures for both the mother and child.

Cesarean section has been rendered quite safe, but this change has improved the infant's chances much more than that of the woman, since we now elect to do a cesarean operation where formerly craniotomy or embryotomy was performed.

Our supposedly slow progress in the last two decades has therefore been more apparent than real, because it has been made along lines not so readily revealed by statistics, as is that of maternal mortality.

Vesicovaginal fistula, formerly so common, was until recently the cause of untold suffering among childbearing women. Thanks to improvement in the art of the accoucheur this condition has become quite rare.

Serious injuries to the baby's head caused by the application of high forceps, as well as the irreparable damage frequently done to the mother by the same procedure, have practically disappeared from the practice of the obstetric specialist, but still not infrequently occur at the hands of the family physician.

Third degree perineal lacerations whether due to narrowing of the pubic arch, or to lack of care and skill in the use of the forceps, rarely happen today under the care of the skilled obstetrician. This injury is still disappointingly frequent in general practice. Lack of surgical

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skill prevents the general practitioner from repairing injuries to the cervix and upper genital tract at the time of delivery, while pelvic floor injuries involving the levatores ani are as a rule very poorly handled by him.

Failure by the general man to make an early diagnosis of complications of labor, such as prolapsed cord, malpositions and presentations, and obstructing tumors, result in the neglect of timely life saving measures, and is the cause of countless obstetric tragedies.

The inability of the untrained accoucheur to competently handle the obstetric emergencies, such as placenta previa, postpartum hemorrhage and ablatio placentae, adds materially to the list of mortalities and increases the morbidity.

Failure to make early diagnosis of disproportion and faulty diagnosis of the station of the head in the pelvis, lead to ill-chosen attempts at delivery with ensuing complications that the best surgical skill can only palliate.

Attempts by the man of only average training to imitate Potter in his method of version, to follow DeLee in his plan for prophylactic forceps with episiotomy, or to do an untimely or ill-considered cesarean section, produce grave consequences that serve to still further emphasize the ever widening gap between obstetrics as practiced by the family physician, and the same art at the hands of the skilled obstetrician.

Recently DeLee has been urging that the classical cesarean operation be discarded, and that trachelolaparotomy be substituted for it in all cases. His figures show a decided reduction in maternal mortality by the use of this method of incising the lower uterine segment rather than the upper one. The greater technical skill required for this operation forbids its use by the unprepared man, a circumstance which may fortunately result in the prevention of some of the frequent deaths now occurring from the classical operation, when performed by men of untrained obstetric judgement.

Transfusion of blood in cases of hemorrhage, a measure frequently resorted to by trained men working in adequate institutions is still another illustration of the surgical procedures demanded in obstetric practice. It is obviously impossible in family work.

I hope not to be misunderstood or misinterpreted. All honor to the family doctor, who cares for confinement cases, under all sorts of poor surroundings, at all hours of day and night, with poor light and untrained help. It is surprising that his results are as good as they are.

I do however wish to emphasize that obstetrics has become a surgical specialty, that the recent advances in obstetrics are practically all surgical, and that surgery of such a type as to demand the highest grade of technical skill, and the broadest and best trained surgical judgment. Whether all this surgery is well or ill-advised is another question. Often to refrain from operative interference requires in-

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finitely more knowledge and experience than is needed to operate. The fact remains that trained surgical skill and comprehensive judgment and experience are prerequisite to modern obstetric practice of the best type.

Two plans present themselves for bringing to the patient this greater technical knowledge and skill demanded by modern methods.

One is to give to the average family physician better training than he formerly received. He handles the great mass of deliveries for the patients of modest means. By the efforts of various interested organizations much has been accomplished in this direction. No one who has had the opportunity to compare the work of the modern medical graduate with that of the men who began twenty or even ten years ago can fail to see the improvement produced by the better teaching of today. This will in time of course be reflected in our statistical data. and is of paramount importance.

The second method available is to bring the service of men already expert to a larger number of women. Indeed the primary purpose of the present paper is to urge the necessity for increasing the actual producing capacity (if one may be permitted to use a commercial term) of each specialist, so that more women may benefit by his skill. This seems particularly desirable for the great middle class, to whom for financial reason, such service is at present unattainable.

Anyone who has considered our present system of conducting private obstetric practice must be impressed with the tremendous economic waste involvod. I think you will all agree that the doctor engaged in this specialty is a very busy man if he accepts thirty cases per month. or an average of one a day, even if his work is limited to hospital deliveries. Although he may have an obstetric resident, and a well organized service, still his patient expects him to be within immediate call over a considerable period of time. This time must be spent at the hospital although the doctor may have no other work demanding his attendance there. Not only must he spend hours in this unprofitable way, but exactly as many of these hours are between ten p. m. and seven a. m., as between ten a. m. and seven p. m. To put the matter briefly, the number of patients that the obstetrician can accept is rigidly limited by his physical capacity for losing sleep, rather than by the amount of work that he could do, were the cases presented to him during a definite portion of the twenty-four hours. As we have previously stated, thirty deliveries per month makes a full schedule under these circumstances. If we compare such a schedule with that of the busy surgeon the contrast becomes at once apparent.

Why can the surgeon develop his clinical work to the point where he actually operates thousands of cases yearly, while the obstetrician must number his by hundreds? Why can he have material for inquiry, research and experience which makes him master of his art. while even the hardest working obstetrician is comparatively inex-

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perienced? This is due entirely to the fact that the surgeon has so organized and systematized his work that he can go into his operating room in the morning, and with a corps of trained assistants he can remain continuously at work until finished. Some emergencies, it is true, must be done at night. But if for every six hours of daytime surgery he were obliged to do six hours of night operating, I believe even the most ambitious surgeon would decidedly reduce his daily quota.

This factor which so definitely limits the work of the obstetrician, not only brings the cost of his services beyond the means of the average patient, but it unfortunately seriously hampers him in the acquisition of experience and technical skill.

What surgeon could gain a reputation for great knowledge if he operated an average of one case daily? Not only is the obstetrician thus limited, but the majority of his cases are normal or nearly so, and consequently play a minor part in developing his diagnostic ability or improving his surgical skill.

The writer wishes to urge the adoption, in our larger centers of population, of a definite plan for so conducting obstetric practice, that a larger number of women, in modest circumstances, may be delivered by the expert accoucheur. This could be accomplished by the grouping of experienced obstetricians for this purpose, each man retaining his own patients who are able to pay for individual service. The plan would require at least two and perhaps three experienced men in the group, who could arrange for alternating the hours on duty to suit their convenience. Two men might alternate day and night service every other month. Any obstetrician could readily care for one or two extra patients daily, if the actual delivery occurred during his hours on duty. Thus the patients of the group would be divided into two distinct classes.

1. Those financially able to command the service of the individual obstetrician, whether by day or night.

2. Those to be confined by the one of the group who happened to be on duty at the actual time of delivery.

Such a plan would serve the twofold purpose of great reduction of cost, to those least able to pay, while it would give to the accoucheur increased opportunity for his own technical improvement.

As the clinic developed reputation, pathologic cases would be referred more frequently. At such a clinic it would be possible to entertain a colleague at any time, with the assurance that he might observe actual operative procedures and newly developed methods, as surgeons habitually do. The development and training of younger obstetricians would be efficient, practical and thorough.

Such a plan the author believes would be a boon to the women whom it served, and would help to answer the criticism that we are not reducing sufficiently the mortality and morbidity of childbearing.

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DISCUSSION

DR. GEO. CLARK MOSHER, KANSAS CITY, MISSOURI.—Dr. Skeel's paper covers in a very graphic manner the progress which has been made manifest in a number of lines of obstetric technic. Those of us whose memory runs back to the last part of the nineteenth century can well recall the frequency with which we came into contact with referred cases of vesicovaginal fistula. Nowadays, as Skeel says, this misfortune is a very rare occurrence indeed. Third degree lacerations still demonstrate that accurate measurements are difficult to make, and the accommodation of passenger to passage is fraught with maternal risk, but these are not so frequent as they were in the past. It would seem that the faulty application of forceps to the unrotated head in a posterior position is one of the gravest offences of the general practitioner of today. As Skeel suggests, the failure to make a diagnosis is more often due to indifference than to ignorance, and we must agree that this counts for much obstetric tragedy.

We also agree with De Normandie and Lynch when they say that we live in an age of hurry and hustle. Nobody has time to wait. Nature is too slow in her method of rotation, so on go the forceps with no regard for position or degree of dilatation. Truly, as Rudolph Holmes says, obstetrics is becoming a lost art, and mainly because of our impatience.

Now, as to the remedy, Skeel is in harmony with all the authorities quoted in our annual report on maternal welfare. Obstetrics is a surgical specialty. In a great many instances our maternity patients are far from being in a condition of physiologic health. The physician must be in every way competent to handle these cases which are surgical emergencies. Even more than this, he must have an obstetric conscience so that he may restrain himself from interference when this attitude is indicated. We must educate the family doctor to become a better obstetric diagnostician.

As to Skeel's proposed innovation of a twenty-four hour service divided into reliefs, each man taking the work coming up while he is on duty, thus conserving his strength by limiting the hours in the hospital, one must be struck by the idea which would enable the family of moderate means to secure high class attention. It is hoped that Skeel may be able next year, during which period the system is to be installed, to report as to the practical result of the adventure.

DR. EDWARD SPEIDEL, LOUISVILLE, KENTUCKY.—We all agree that obstetrics is a surgical procedure. We also realize that an obstetric procedure is always performed under conditions so absolutely inferior to the splendid surroundings of the organized surgical operation that it is astonishing that the obstetric specialist succeeds even in the well-arranged maternity hospital. When you consider, then, that the majority of such obstetric procedures have to be performed in the house by comparatively untrained men, you can readily understand how much improvement is necessary in obstetrics.

Again, when you realize that the man who would hesitate to perform an appendectomy has no hesitancy whatever to perform any of the obstetric operations except perhaps cesarean section, then you can readily understand that such an attitude must result in a great mortality. The remedy for better obstetrics is, of course, that all of these operations be performed in good maternity hospitals, and that even if the maternity specialist is called in a private house to perform a delivery upon a complicated case, he would find it wisest under those circumstances to have the patient transferred to a hospital where better conditions prevail.

The idea of having a corps of physicians who relieve one another in obstetric cases, is to be desired, and if that can be accomplished it will result in much better work being done by groups of physicians than can be done by a single obstetrician at the present time.

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