Am J Obs Gyn 1931 V-22

WHAT ARE THE FUNCTIONS OF A UNIVERSITY WOMAN'S CLINIC?*

By H. J. Stander, M.D., Baltimore, Md.

A UNIVERSITY woman's clinic, or the well-known "Frauenklinik" of the Germans, is a hospital limited to the care of pregnant and parturient women, as well as women suffering from conditions, affections or diseases associated with, or part of, their reproductive system. The purpose of such a clinic is to afford the best possible care for all patients entering its doors, to properly educate medical students in the art and science of obstetrics and gynecology, and lastly to encourage and sponsor investigations in the all too numerous problems awaiting solution in this field of medicine.

It is not the purpose of this paper to trace the origin and development of the "Frauenklinik" or Woman's Clinic, but it is well that we recall Johann Jacob Fried, who undoubtedly founded the first true woman's clinic in the beginning of the eighteenth century, in Strasbourg, Germany. It must also be pointed out, however reluctantly, that while the woman's clinic was developed from Fried's original concept as a comprehensive whole in Germany, this was not the case in France, England, or the United States of America. In these latter countries midwifery, or obstetrics usually followed one path, and its sister or daughter branch, gynecology, traveled a different way and often became affiliated with surgery; and so men have been trained as obstetricians or as gynecologists, the two groups having nothing or very little in common. It is only recently that most of us in this branch of medicine have begun to realize that we are far behind the Germans, and that our teaching of medical students, and consequently the medical care of our patients, must be greatly lacking.

It will take us too far afield to discuss the conditions and circumstances which lead to this unfortunate separation of the two branches which constitute that part of medicine pertaining to the reproductive system of the woman. Suffice it to say that no one practicing obstet-

*Read at a meeting of The Alumni Association of the Lying-In Hospital, New York City, December 10, 1930.

history-of-obgyn.com
obgynhistory.net

ries, without a first-hand appreciation of pelvic surgery or gynecology, can do full justice to his patient; and this applies equally well to the gynecologist who is untrained in obstetrics. A few clinics in this country have fortunately adhered to the German concept of a woman's clinic, and to these we owe a great deal for preserving the ideals of Fried and his pupil, Roderer. During the past few years we have happily seen several of our leading universities taking the necessary steps toward establishing woman's clinics, and thus cementing the two branches of this medical specialty into a complete unit, which must inevitably result in more adequate care of patients, better teaching of students, and a keener appreciation and further development of research.

Why this special interest in, and this endeavor to improve the teaching of obstetrics and gynecology? The main reason lies in the fact that our maternal and fetal mortality in this country is appalling, and that inadequate obstetric training is the forerunner not only of a heightened maternal and fetal mortality, but also of a large part of gynecologic operations.

In a very thorough statistical study of maternal mortality in the United States, covering a twenty-two year period, ending in 1921, Woodbury showed that the maternal death rate increased from 13.3 in 1900 to 16.9 per 100,000 population in 1921. From puerperal infection it increased from 5.7 in 1900 to 6.8 in 1921; and from all other causes it increased from 7.6 in 1900 to 10.1 in 1921. Woodbury, in comparing maternal mortality in the United States with that in 20 foreign countries which have official registration statistics, finds the death rate in this country the highest, being 7.99 per 1000 live births; while Denmark and the Netherlands have rates of only 2.35 and 2.42, respectively. He states that although the comparability of these figures must be carefully studied before one can draw any final conclusion, it is evident that the United States ranked among the countries with the highest rates, such as New Zealand and Chile; while the British Isles and Germany occupied an intermediate position, and the Scandinavian countries and the Netherlands showed low death rates. Since statistics compiled by this author show that the total number of confinements is only about 3 per cent larger than the number of live births, the mortality rate calculated on live births gives us a fairly close approximation of the true risk of dying in childbirth; furthermore, to avoid errors arising from differences in definition of stillbirth, it is preferable to use the rate based on live births when comparing different countries. We may then express the maternal mortality rate in this country in another way, namely, that one in every 125 women die incident to childbearing; a truly staggering sacrifice. Nothing has been accomplished in the past quarter of a century to reduce this frightful death rate incident to childbirth.

history-of-obgyn.com
obgynhistory.net

Comyns Berkeley, in a brilliant lecture on the teaching of midwifery, delivered last year, stated that public opinion in England has at last been roused because of the fact that the maternal mortality and morbidity in the British Isles had not been lowered for the last twenty years, a statement which cannot be made about any other medical condition or disease. He places most, if not all, of the blame for this on the very inadequate teaching of midwifery and the diseases of women. He writes: "Midwifery and the diseases of women form one-third of all qualifying examinations for the medical student, and it is perhaps the most important of all three parts dealing, as it does, with the well-being of those who supply the nation with citizens. Again, for some reason which its teachers can never understand, midwifery has always been regarded as a specialty in the hospital world and probably also in the minds of the lay public. It is no more a specialty than medicine and surgery, forming as it does one of the Trinity of medicine. The Medical Act draws, and knows, no difference between medicine, surgery and midwifery."

I believe there can be no doubt that the inadequate teaching of obstetrics in most of the medical schools of our country is the largest single factor in the production of that high maternal mortality; and it is only by an extension and improvement in the teaching of this branch of medicine that we can ever hope to reduce this overwhelming death rate.

From this, you will observe how intimately bound together are the first two functions of a woman's clinic, the care of patients and the teaching of students. We can only hope to improve the medical care of patients and reduce the risk incident to pregnancy by affording better teaching facilities and by graduating men and women better trained in obstetrics and the diseases of women. I am not a believer in the argument that the student must obtain his experience after graduation as he does in medicine and surgery. While a student, he now gets more training in these last two than in obstetrics and gynecology, and yet he may need his knowledge of obstetrics far more urgently immediately after graduation. To quote Berkeley once more: "It appears to be forgotten or perhaps not realized, that the position of midwifery, qua the newly qualified man, is entirely different from that of medicine or surgery. General practitioners, as a body, do not practice surgery, but call in a surgeon or send their patients to a hospital. In the case of a medical disease, the practitioner has, in nearly every instance, time to turn around, and if necessary he can call in a physician or send his patient to the hospital. On the other hand, the first day a medical man is in practice, he may be 'up against' a midwifery complication which requires his immediate attention if the life of the woman and her child are to be saved, and in which there is no time to wait for the assistance of an expert. It seems to be forgotten, more often than not,

history-of-obgyn.com
obgynhistory.net

that an obstetrician is dealing at the same time with two lives, while the physician or surgeon is dealing with one at a time only." In this, I agree fully with the writer, and also when he concludes that our universities should extend the time allotted to the teaching of obstetrics and gynecology to equal that given in either medicine or surgery.

I shall now discuss under separate headings the three functions of a university woman's clinic; the care of patients, the teaching of students, and the fostering of research.

CARE OF PATIENTS

The most important function of a woman's clinic is to provide adequate nursing and medical care for all admitted to public ward or private room. It may be noted here that the Woman's Clinic of the New York Hospital-Cornell Medical College Association will have 112 public beds out of a total of 138 obstetric beds, and 32 public ward beds out of a total of 42 gynecologic beds. From these figures you will observe the very limited space allotted to private patients, amounting to only 26 out of a total of 170 beds, or about 15 per cent of the total capacity.

Under the full-time scheme, the chief of the clinic and a small number of assistants spend their whole time at and in the interests of the clinic. The running of a large woman's clinic, together with teaching and a certain amount of individual research, consumes almost, if not all, the time of the chief; and he thus has very little time to devote to private practice. I have held a full-time position in medicine for the past eight years, and know this to be the case. Full-time medicine was founded with the express purpose that the head of a department and a few assistants could give all their time to the details of the clinic, teaching and research. The chief of a university woman's clinic, therefore, should be interested primarily in these three functions, and any private patients that he may have should constitute a very small number, and take up a decidedly minor part of his time. This, of course, also applies to his few full-time assistants.

It is my idea that in the care of patients, that is, the clinical aspect of the clinic, the burden must be borne by part-time as well as full-time men. The reasons for this are that the full-time staff is too small to adequately handle a large clinic; and secondly, and perhaps of more importance, that it would lead to stagnation if a fairly large group of men, including those in private practice, were not utilized in this prime function of the clinic.

TEACHING

The medical student, the graduate who wishes to prepare himself for the practice of obstetrics and gynecology, and the practitioner who wants to spend a few weeks or months in the clinic, constitute the group

history-of-obgyn.com
obgynhistory.net

that must be taught. I agree with my present chief, Dr. Williams, that it is the duty and privilege of a university clinic to foster the teaching of the first two groups, and that the third group who wish to take postgraduate courses, should be referred to specially devised postgraduate schools. This, of course, does not mean that the general practitioner will not be welcomed to spend a few days in the clinic; but regular courses or work solely designed for his benefit had better be given in these special postgraduate schools.

Here again, in the teaching of medical students and graduates, the full-time staff urgently needs the help of the part-time specialists. The teaching can be broadened, improved and made of greater interest, by the utilization of the part-time men on the staff. The major part of the teaching, however, must be cared for by men who can give their whole and undivided time to the preparation and carrying out of this task.

RESEARCH

It is not necessary that I emphasize the many problems in obstetrics and gynecology which are in urgent need of solution. The etiology and treatment of puerperal infection, the toxemias of pregnancy, the nature and cause of menstruation, the endocrine and metabolic changes associated with the menopause, the cause of labor, the etiology of most spontaneous abortions, the best methods of treatment of many abnormalities appearing in the third trimester of pregnancy, the etiology of uterine displacements, as well as of benign and malignant growths of the female reproductive system, represent a few of these problems. For the solution of many of these questions, the investigator, in addition to being a competent clinician, must be trained in one or other of the fundamental biological or physical sciences, must possess the facilities and be prepared to devote a considerable portion of his time whole-heartedly to the question in hand. For this purpose again a full-time staff consisting of properly trained men is essential. This, however, does not imply that the university clinic should not welcome and afford opportunities to men engaged in private practice, who have the urge, the training and the time to pursue an original investigation.

I wish to emphasize here that the object of research in a woman's clinic is to solve, or attempt to solve, problems with a direct clinical bearing, as the more academic or pure scientific questions can far better be studied in the preclinical or academic departments. In order that a real bedside appreciation of problems may be had, and that the proper critique as to the solution and application of such questions may be exercised, it is essential that the staff of the clinic be composed of clinically well trained men with a knowledge of one or other of the basic sciences. It would lead to greater efficiency both clinical and experimental, and to more valuable productivity were the staff to be

history-of-obgyn.com
obgynhistory.net

composed of first-rate clinicians, each one well trained in a different fundamental science, so that anatomy, embryology, bacteriology, pathology and chemistry were all duly represented in the clinic. This is an ideal state toward which we can only hope to strive.

In concluding these remarks, I cannot refrain from commenting upon perhaps the most universal criticism of full-time medicine, which is, that the men on the full-time system are usually poor clinicians. This criticism is undoubtedly valid in some instances, but we must not forget that the system is still young, and passing through its experimental stage. It is not always an easy matter to procure men with long clinical experience who are imbued with university ideals, possessing the necessary fundamental training and willing to sacrifice a lucrative practice and assume the leadership of a large university clinic at a moderate salary. Then, also, it is well to remember that many years of private practice in obstetrics does not necessarily mean a vast experience and thorough training in the abnormalities and difficulties of the specialty. A young man on the active full-time staff of a well run moderate sized woman's clinic will see and do more abnormal obstetrics in a year than his confrere in private practice in perhaps five years, or more. It is not so much the number of years spent, as the amount of material observed, thoroughly studied, and well treated, which is the basis of sound training. To my mind, the fact that the man has schooled himself prior to his clinical training in such exact sciences as biology or bacteriology, would enable him so much the better to master his clinical work. By this, I do not mean that "laboratory men" should constitute a full-time staff, but I do insist that a training in a fundamental science is no contraindication to sound clinical training. The full-time staff of a university woman's clinic certainly has an unusual opportunity to acquire clinical proficiency.

It is also well for us to bear in mind that the only excuse for full-time medicine is to produce better doctors in every sense of the word; and if this is not accomplished, then the full-time system is a failure. We have enough faith in the system to give it a fair and thorough trial, and certainly welcome constructive and helpful criticism; but criticism engendered from personal animosities and jealousy will benefit no one.

There is one last criticism directed toward the full-time medical man, and that is that he does not possess that "indefinable something" gained from contact with private patients on the outside. Today, most, if not all, of our obstetric patients are delivered in hospitals, and certainly our operative gynecologic patients are treated in the hospital. If the full-time man is conscientious (and we can lay down no rules for those who are not), he will treat his limited number of private patients as well as the private specialist treats his. He will come in as close touch, and I speak from first hand information, with his patients as does his

history-of-obgyn.com
obgynhistory.net

associate in strictly private practice. But, whether we discuss the clinical ability or the experience gained from private patients, in the end it is the individual rather than the system of training that counts.

From the foregoing remarks on the prime functions of a university woman's clinic, it must be clear to you that such a clinic differs radically from the lying-in hospitals, maternity hospitals, and women's hospitals that are founded along purely humanitarian lines, and not at all, or only indirectly, concerned with the education and training of medical students and graduates, and are not designed, equipped, or endowed for research. There will always be a place for these latter institutions, but it is fervently hoped that the universities throughout our country will follow the lead of the few medical schools, in which we are now happy to include the New York Hospital-Cornell Medical College Association, that have seen the light and followed, although somewhat tardily, the example of the great German universities with their "Frauenklinik" or Woman's Clinics.

history-of-obgyn.com
obgynhistory.net