Am J Surgery 1936

MATERNAL MORTALITY AND OBSTETRIC CONSCIENCE*

THE maternal death rate is a cause of grave concern. It is clear however, that modern limitation of the size of families with growing legions of abortions, relative increase in the number of primiparae with their higher incidence of difficult deliveries, and the growing age of primiparity itself, seriously affect comparison with older figures. Death certificates too, have been subjected to closer scrutiny, the New York survey alone indicating a total error of nearly 18 per cent. It is probable that improvement in the death rate, though not apparent, is none the less real.

Failure of statistics to yield to medical papers and discussion, revision of the undergraduate curriculum, certification of specialists, increased numbers of hospital beds, governmental investigations and popular education and movements is a mystery to some of us. Yet obviously all these have not been enough if statistics are accepted at their face value.

So long as obstetrics is an art, it will never be possible to teach more than obstetrical catechism in the medical schools; there is neither opportunity nor time enough to teach that which must be learned by practice, not precept. The young graduate is far better trained than his predecessors, yet we are still waiting for tangible results.

Statistical analyses are but a means to an end, and international comparisons are particularly futile. We are apt to lose sight of that. Of themselves statistics accomplish nothing, merely pointing out the avoidable coefficients of maternal mortality. It is a fact that all studies show that approximately one-half of the maternal deaths are preventable, yet even these findings are not conclusive. Though based on accurate information, interpretation of human clinical data is not easy. The specialist's conscience, or the statistician's, highly developed and rigidly consistent, though aware of important social and economic trends may not give them true values when assigning deaths to preventable columns.

Education of the public is valuable and necessary, but time consuming and difficult. Told that complications are preventable, women expect none. They should be told that most of their hazards can be forseen and controlled, but that pregnancy and labor are by no means safe undertakings. That is quite different. The time worn concept that childbirth is a physiological process should be summarily discarded as a harmful platitude. DeLee has insisted upon this for years. There will always be mortality, and it cannot be prevented by "protesting to your physician, to your mayor, to your governor, to your congressman, to your president." This interesting advice to the mothers of America appeared last March in a magazine with wide circulation among women in this country. The press can do us great service, but overemphasis on preventability will only hurt the good cause.

A very large proportion of maternal deaths is inevitable. It is not a simple problem; in fact it is a very complex and difficult one. Antepartum hemorrhage can not be prevented, nor will good management ensure safe delivery. Eclampsia may occur in spite of excellent supervision. Sepsis, the yardstick of intrapartum care, may follow spontaneous delivery, and does occur with increased incidence in operative deliveries where no other method of treatment was possible. The diagnosis of disproportion is not easy, and its management by induction, trial labor, difficult forceps or cesarean section involves alternative but

* Read before the Brooklyn Gynecological Society, May 1, 1936.

history-of-obgyn.com

no less considerable factors of risk. The less common presentations of the fetus and, more than anything else, posterior positions of the occiput increase maternal as well as fetal mortality.

No doubt the death rate is high. Certainly we are not satisfied. In the final analysis however, we are not concerned with percentages of preventability, or the recriminations which they invoke. If the mortality is unnecessarily high, and we believe it is, it can be reduced. Social and economic factors are involved, for surely the deaths from intentional abortion are beyond our control. Statisticians assign the mortality of criminal abortion to homicide; deaths from self-induced abortion are assigned to puerperal causes, but these too are largely criminal and not self-induced, though they may appear to be. Reduction of mortality is a social as well as a medical problem.

Prenatal care must be adequate, not perfunctory. In toxemia and hemorrhage its function is plain and well understood. Not so clear however are its implications in the all important matter of safe delivery, yet if it does not accomplish that, it is worth nothing.

We must remember that anesthesia, in itself a blessing, in a great many cases slows labor and increases the incidence of forceps deliveries. Interference, whether indicated or not, is the commonest cause of puerperal infection. Skill and judgment so necessary for any operative delivery other than low forceps, are no less requisite when we allow women to remain long in labor. Placenta previa and ablation of the placenta are formidable complications which tax the skill of the most expert, and eclampsia is no different. The outstanding feature of the Children's Bureau survey was that one-quarter of all the maternal deaths followed abortion; they were mostly due to sepsis, accounting for nearly half of all the deaths from puerperal septicemia, the greatest single cause of maternal mortality. That is important. When we are told that 19 per cent of the deaths in New York City, 24 per cent in Boston, were due to cesarean section, we must listen. Cesarean is not for the novice or the casual obstetrician.

The hospital has very definite obligations in this matter of maternal welfare. Large or small it must closely supervise the obstetrics practiced within its walls, for responsibility for the patient does not rest entirely with the doctor. Not all hospitals are safe places for expectant mothers, and the small institution may be excellent, or it may be sadly inadequate, hardly deserving the name of hospital at all. Every hospital should be safe. This is not only what women rightfully expect, but the best interests of the institution, patient and doctor are served no other way. Facilities must be mobilized for advice and help, consultation must be easily obtained when indicated. Nothing must be left undone. The patient must be protected, the physician supported whether he wishes it or not. Then he will grow in knowledge and experience as he multiplies his contacts with the form and substance of good obstetrics. This is the best kind of postgraduate education.

Established moral values have broken down. Conscience asks if this is right, and the inner voice is always so clear that it is impossible to mistake it. Whether it is an intuitive or acquired facility of moral perception, conscience covers everything within a man that has to do with the decision and direction of his moral conduct. Every one of us worthy of our high tradition carries with him an accusing or a comforting witness. He only is content whose conscience is clear.

The obstetric conscience is acquired, and skill and judgment with it. It may be defined as a sense of obligation to obstetric principles. It never swerves from the basic principle of preservation of normal function. It never interferes unnecessarily, unwisely or without counting the cost. It stands firm against the importunity of sympathetic but unknowing relatives. It is proof against hurry and convenience.

history-of-obgyn.com

It constantly weighs two lives in the balance of experience and knowledge. It crosses no frontiers without a responsible guide. It never forgets its plain duty. God help her who is so unfortunate as to place her trust in one who scoffs at conscience and God help him, too!

The experienced general practitioner, with an obstetric conscience, is the best practitioner of obstetrics. We need more obstetric physicians, less surgeons. We need hospitals keenly conscious of their responsibility to the public.

Nearly a hundred years ago (1842) Oliver Wendell Holmes, reading his "Essay on the Contagiousness of Puerperal Fever" before the Boston Society for Medical Improvement, spoke to the medical profession of the world:

The woman about to become a mother or with a newborn infant upon her bosom, should be the object of trembling care and sympathy wherever she bears her tender burden, or stretches her aching limbs. The very outcast of the streets has pity upon her sister in degradation, when the seal of promised maternity is impressed upon her. The remorseless vengeance of the law brought down upon its victims by a machinery as sure as destiny, is arrested in its fall at a word which reveals her transient claim for mercy. The solemn prayer of the liturgy singles out her sorrows from the multiplied trials of life, to plead for her in her hour of peril. God forbid that any member of the profession to which she trusts her life, doubly precious at that eventful period, should hazard it negligently, unadvisedly or selfishly.

Time changes. Conscience remains.

Charles A. Gordon.

history-of-obgyn.com