

# Presidential Address

## *The American College of Obstetricians and Gynecologists*

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### *Fifth Anniversary Meeting, 1956*

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TODAY WE ARE assembled in the fifth anniversary meeting of this organization. It seems appropriate and proper at this time to analyze and assess our accomplishments and to think of the future progress of the College.

A brief recital of the genesis of the American College of Obstetricians and Gynecologists will be of interest, especially to the newly elected Fellows.

In 1944 the preliminary organization meeting of the National Federation of Obstetric and Gynecologic Societies was held in St. Louis, with the idea that such an organization would serve as a coordinating group for the United States.

It was long apparent to many members of the component societies of this organization that a national organization composed of individual, personal memberships for obstetricians and gynecologists was necessary. Any such movement needs men of foresight, vision, and leadership, and it was Philip F. Williams of Philadelphia, who with conviction and determination perceived the importance and the necessity of such an organization to strengthen and cement the obstetricians and gynecologists together. It became evident

that the National Federation of Obstetric and Gynecologic Societies would be the natural foundation on which a conversion to the American Academy of Obstetrics and Gynecology could be made.

The American Academy of Obstetrics and Gynecology was incorporated on August 4, 1951, and Woodard D. Beacham was its first president.

The Academy took hold when it became apparent that it was formed for the purpose of bringing better obstetrics and gynecology down to the "grass roots" level in every place, everywhere in this country and Canada. The Academy offered Fellowship to thousands of obstetricians and gynecologists whose qualifications and limitations met the requirements and would give them for the first time a chance to funnel their professional activities and academic interests into a reorganized organization of national assembly—an organization whose efforts were to extend not only to assembly meeting but to bring forth a unified profession for the care of patients, education, and administration. The latter became the resolution of the Academy policy some time later.

No better indication of the enthusiasm for this organization, now The American College of Obstetricians and Gynecologists, can be shown than by its present membership of

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3819 members, with a newly elected Fellowship of 567.

There is always some doubt in organizations as to the rule of the majority relative to policy making and the perpetuation of its officers. I wish to emphasize that when the American Academy of Obstetrics and Gynecology was organized it was set up so that the rule of the majority would make the policies, direct the function, and determine the ultimate success of the organization. It can be pointed out that, even though the name of The American Academy of Obstetrics and Gynecology has been changed to The American College of Obstetricians and Gynecologists, in substance it is the same organization with a new name—but still the same democratic organization. You, the Fellows, not only select the officers from the local to the national level, but also determine the policies, functions, and direction of the College. As individual members you must realize the responsibility that is yours and must recognize the fact that in our democratic organization the ultimate success of the College is wholly your responsibility.

The annual assemblies as well as the district meetings are of paramount importance. It has been my privilege to have been invited to attend all the district meetings. They were extremely informative and educational. Great effort was expended in their preparation, and pride and enthusiasm were observed as a result. It has been refreshing to listen to the excellent presentations by the residents, who will be identified as Junior Fellows in the future. The caliber of these presentations was such that the essayists could be differentiated from their seniors only by their youthful faces. Such opportunity in their formative years is stimulating and of inestimable value. This part of the district programs must be encouraged.

The excellence of the programs at the district meetings warrants better attendance. I feel that the district meetings have a definite place in our organization. In addition, they

give the Fellows a chance to present papers which could not be presented at the national meeting because of the program limitations. Such presentations are often worthy of publication and should be submitted to our Journal.

It is my conviction that district meetings should be open to all physicians with an interest in obstetrics and gynecology. This, of course, must be dependent in part upon the physical facilities and other limitations of the district meeting. Some districts have already agreed with this policy but others have not. It seems to me that the ideology, purpose, and philosophy of this organization have not changed since its inception, and it still holds that we are pledged to improve the practice of obstetrics and gynecology in every conceivable manner. This is not debatable.

Let us not place a picket fence around this organization and exclude those who will benefit the most by our programs. This thought has been stated best in a Presidential Address before the American Association of Obstetricians and Gynecologists by Samuel Cosgrove, a distinguished Fellow of this College:

If we specialists and teachers actually feel the effects of possible changes in medicine in less degree than some of our fellows, it is the more incumbent on us to exercise assiduously the glorious privilege of passing on to those who surround and depend upon us, as well as to those who shall follow us in the years to come, all the lessons of history, of personal experience, of observation, of adroitness, of attainment, which we possess. This to the end that in spite of environmental pressures the attainments of medicine shall not grow less, but shall proceed to develop to an even more glamorous future. Let us then, in the presence of malign threats which none of us can measure, solemnly rededicate ourselves to the obligation which we have inherited from those who taught us and continue, no matter what our individual circumstances are, to "gladly teach."

Apropos to my philosophy and to the previous quotation, I have compiled some sta-

tistical data relative to the year 1954. These are a compilation from the Children's Bureau with the American Medical Association as the source. I appreciate the assistance of Dr. Marian M. Crane and Dr. Eleanor P. Hunt of the Children's Bureau.

There were 4,087,471 total births (live and still) registered in the United States.

Physicians in practice exclusive of government service numbered 192,914, of these 7079, or 3.7 per cent, limited their practice to obstetrics and gynecology. In the total group, there are listed 64,716 general practitioners. Thus there are 158 generalists and only 17 specialists to each 10,000 total births.

It is of interest to group the physicians in our specialty by states having the highest, middle, and lowest per-capita incomes. In the 16 states of highest per-capita income, there were 4771 specialists and 2,123,408 total births. In the 16 states including the District of Columbia of middle per-capita income, there were 1285 specialists and 962,297 total births. The last group of 16 states with the lowest per-capita income had 1,001,766 total births and there were 1023 specialists.

These figures show that about half of the births in the United States occur in the highest per-capita income group of states, and about one-fourth each in the middle and low per-capita income states. Note that over two-thirds of the obstetricians and gynecologists are in practice in the high per-capita income states, while the remaining third are in practice in all other states. The number of obstetricians and gynecologists per 10,000 total births is 22 in high-income states, 13 in middle-income group of states, and only 10 per 10,000 in the low-income states. In the middle- and low-income groups of states availability of general practitioners is also lower than elsewhere in the United States. Thus the ratio of total physicians to births

is considerably below the national average in these states.

Maternal and infant mortality statistics follow the same trend or pattern in the high per-capita income states and it becomes obvious that this should be true because of the availability of both the specialists and the general practitioners in these areas. The maternal and perinatal mortality figures parallel each other in great part and reflect the character of the practice of medicine in these areas. This will be shown later.

These facts show that the maternity care responsibilities of physicians in the states with more limited financial resources are heavier than in the well-to-do states. At the same time, the number of experts in maternity care who must work with generalists and other physicians in these states to maintain high standards of maternity care is smaller than in the states with high per-capita income.

It is the widespread training and educational programs in our specialty which provide more and *better qualified specialists*, and, at the same time, *more competent general practitioners*. Do not forget that education is a part of our stated policy, with no limitations or qualifications.

Another significant function of the College rests in the work of the Standing and Ad Hoc Committees. The Standing Committees are usually represented by all districts, and members rotate with a 3-year tenure of office. The system of rotation results in replacements each year. Thus they are less apt to become static, insure stability, and result in greater interest, activity and achievement.

It has been my policy in filling the committee appointments to have all districts represented by appointees having a particular interest in the area represented; however, it should be understood that all committees are working ones and the appointee should accept or reject his assignment based upon the

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area of his interest and his willingness to work.

*The Committee on Committees.* This committee has assessed, reconsidered, outlined, and proposed amended function for each committee during the past year. It has also reviewed the personnel and made recommendations accordingly. This committee has recommended a handbook to be printed and revised annually, showing the organization, composition, and function of each committee. Its work is of monumental importance. It is to be commended for work well done, for it has added to the effectiveness and productivity of all our committees.

*The Committee on Maternal Welfare.* Of great importance has been its official representation on the Joint Conference on Maternal Mortality Programs and Guides for Maternal Death Studies sponsored by the Committee on Medical and Child Care of the Council on Medical Service of the American Medical Association.

It is interesting to note that there are 15 states that have active Committees on Maternal and Child Care; 15 states have no committees, and 19 states have committees which are more or less inactive.

*Committee on the Care of the Fetus and Newborn.* This committee is working on a liaison project with the American Academy of Pediatrics and the American Academy of Cerebral Palsy related to the obstetric aspects of cerebral palsy, the improvement of death certificates and fetal death statistics, and are to continue their efforts to seek representation on the Sub-Committee of the Department of Health, Education and Welfare concerned with these matters. This committee is also to clarify our definition of pediatric care as it concerns our Fellows and its effect on eligibility for Fellowship.

Of great interest and concern to our Committees on Maternal Welfare and Care of the Fetus and Newborn, and to the College as a whole, is a statistical research project entitled "Uses of Statistics on Hospital

Maternity and Newborn Infant Services" initiated by the Children's Bureau of the Department of Health, Education and Welfare.

The project will be a joint undertaking of The American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the Children's Bureau. An executive committee composed of two representatives from each of the three sponsoring agencies will have over-all responsibility for general administration and direction of this project. Under this committee, a project director, Dr. Schuyler G. Kohl, with his personnel, will plan and conduct the study which cover a period of three and one-half years, with a considerable financial outlay for which the American College of Obstetricians and Gynecologists will act as the fiscal agent. In general, these investigations will be carried out in community hospitals and hospitals away from medical centers.

I feel that the deep interest and cooperation of the College referable to the organization of maternal mortality studies, maternal death guides, and the foregoing research project indicate the spirit of team work with other organizations that has developed within the College.

The statement has been made that the United States is the safest place in the world to have a baby, and there has developed a complacency as to what we have accomplished. Some say "Good enough!" But "good enough" is not good enough for us. In a report of perinatal mortality studies in New York City published in 1955 by Dr. Kohl, it is reported that 35 per cent of deaths were preventable. Specifically, there were reported errors in medical judgment in 31 per cent, unsatisfactory pediatric care in 27 per cent, errors in medical technic in 24 per cent, and *faulty prenatal care* in 22 per cent. This should cause us to reflect.

The latest figures as reported September 14, 1956, by the Division of Research, Program Analysis Branch of the Children's

Bureau for the year 1954, show that mortality rate for infants under one year was 26.6 per 1000 live births for the United States, with a total of 106,791 deaths; deaths under one month totaled 76,624, or 19.1 per 1000 live births; and under one week, 67,353 deaths, or 16.8 per 1000 live births.

In 1954, 36 of 1000 total births in the United States resulted in stillborn infants or infants unable to survive beyond the first month of life, and 88 per cent of these neonatal deaths occurred in the first week.

What are the facts in relation to maternal mortality? I have taken it upon myself to obtain some recent figures compiled by the National Office of Vital Statistics and obtained from the Children's Bureau. These statistics have been compiled for 1953-54, and segmented into state classifications of 3 categories. Sixteen states with the lowest mortality rate had 829 deaths, with an incidence of 1.6 to 4.0 maternal mortality per 10,000 births; the next 17 states represented 1362 deaths, with a spread of 4.6 to 5.3 maternal deaths per 10,000 live births; and in the last 16 states 2299 deaths, with a spread of 8.6 to 17.3 maternal deaths per 10,000 live births. The 4 states with the highest mortality rates had 10.9, 11.0, 13.3, and 17.3 maternal deaths per 10,000 live births. In the United States there were 4490 maternal deaths, with an average rate of 5.7 per 10,000 live births and a total of 139,366 live births unattended by a physician in 1954.

Our progress in maternal mortality since 1920 is of interest:

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|------|----------------------------------------------------------|
| 1920 | 12,058 maternal deaths or 79.9<br>per 10,000 live births |
| 1940 | 8,876 maternal deaths or 37.6<br>per 10,000 live births  |
| 1954 | 2,105 maternal deaths or 5.2<br>per 10,000 live births   |

These figures show a tremendous decrease in maternal mortality in the last few years but *we still have far to go*.

*Legislative Committee.* This committee has been very active and has had to make many decisions of vital importance particularly with several bills designed to provide Medical Care for Dependents of Uniformed Forces. A bill on Dependent Medical Care or the Medical Care Act, now Public Law 569, was finally signed by the President in June 1956. All national, district, and section officers were alerted to make immediate contact with their individual state medical societies. It is gratifying to report that in the efforts of the College to render assistance, the American Medical Association and the Department of Defense gave every consideration and designated the channels through which we could direct our efforts in relation to the armed forces.

*The Professional Standards Committee.* This committee has accomplished the tremendous task of preparing a manual on professional standards. This is in skeletal form and I am sure that every one of us is looking forward to its final publication.

*The Audio-Visual Committee.* This committee is working on a catalogue of aids and mechanisms in this field.

*The Parliamentary Committee* has performed a tremendous function in reorganizing and further clarifying the by-laws.

*The Mead Johnson Scholarship Award Committee* is concerned with awards for graduate training in our specialty.

*The Public Relations Committee* is concerned with lay publications, radio, and television, and the ever-increasing problems of the public relations of our organization. Many public-relations problems are already being channeled to the College. This committee has an important function relative to the press: It is attempting to create an understanding of the physician's point of view, promoting a journalistic sense of responsibility in medical matters; at the same time, it must give the profession a better understanding of the press. Certain cross purposes exist, since professional discretion

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for the physician and freedom of speech for the press are two contrasting ethical concepts.

*The Committee on Resident Training* has extended its activities to include the problems of obstetric anesthesia, by working with a committee of the American Association of Anesthesiologists.

*The Ad Hoc Committee on Therapeutic Abortion and Sterilization* was appointed this year. Because of the many controversial issues, we shall be particularly interested in this committee's recommendations.

Time does not allow me to mention the accomplishments of all of our committees. All are important, all are working committees, and therefore all are an important function of this organization.

In the field of education, there have been requests from hospitals and medical schools that The American College of Obstetricians and Gynecologists *state and clarify in writing* the official policy concerning the unification of obstetrics and gynecology into a single department in hospital and medical-school administration.

The American College of Obstetricians and Gynecologists has been invited to become an additional sponsoring society for the American Board of Obstetrics and Gynecology and has been requested to appoint 3 of its Fellows to serve as members of the Board. This invitation, one of honor and distinction, was accepted.

The American College of Surgeons was advised that our Executive Board reaffirmed its good will and continued support of the organizational functions of the College and further advised the American College of Surgeons that our Executive Board would consider favorably an invitation to be represented on its Board of Governors. This has

been acted upon favorably by the College of Surgeons.

The American College of Obstetricians and Gynecologists has a joint representative with the American College of Surgeons in the person of John I. Brewer on the Joint Committee on Accreditation of Hospitals.

An important liaison between The American College of Obstetricians and Gynecologists and the American Hospital Association was established by the appointment, on their request, of Franklin L. Payne to the Joint Commission on Professional Practice of the American Hospital Association.

Our Executive Board has accepted the invitation of the International Federation of Obstetrics and Gynecology to serve as the sole official representative of the United States and the sole contributing member to this organization. This is contingent upon the sanction of every obstetric and gynecologic organization within the confines of the United States. Through the International Federation, we can familiarize ourselves with all obstetric and gynecologic advances throughout the world. This is just one more avenue by which international good will can be established and at the same time obtain medical dividends.

I am proud of the College. Its growth has been phenomenal, its course has been constructive and productive, and it has absorbed the best in our specialty. I have faith in its work and great hopes for its future, even though I have not been too charitable in its assessment.

I wish to take this opportunity to thank the Officers and Fellows of this organization for the splendid support given me throughout the year. It has been a rare experience and a distinct honor to have served you.