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ADDRESS.

ADDRESS ON OBSTETRICS.

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In taking up the evidences of recent progress in obstetrics, I wish first to call your attention to the growing appreciation in all civilized communities of the services of the skillful accoucheur. Then we remember that when Dr. Wm. Shippen, Jr., began his lectures in Philadelphia, in 1765, a little over a century ago, the practice of midwifery was entirely in the hands of nurses, mostly of the Sairy Gamp style so graphically described by Charles Dickens, and the physician was only called in after some grave emergency had arisen and the life of the patient imperiled. When we recall the fact that it was not until 1808 that the trustees of the University of Pennsylvania created an independent Chair of Obstetrics in the faculty, and made the attendance upon the lectures obligatory upon the students, we begin to realize the great strides that have been made in this, the latest born department, the most vigorous child in the entire medical curriculum. Very much light has been thrown upon this subject by recent advances in bacteriology and in antiseptic surgery. We no longer discuss the question of the contagiousness of puerperal fever; but, when sepsis unfortunately occurs, we proceed at once to determine the source of the infection, eliminate the poison, and check its pernicious activity. Increase of knowledge brings increase of responsibility. The obstetrician of the present day is a man of vastly more information, has a higher appreciation of the importance of his chosen department, and consequently has a keener sense of the grave responsibility resting upon him than those of earlier times. Carelessness, ignorance and neglect can no longer be tolerated in the lying-in room in view of the serious consequences which result and which may, almost in a moment, convert the house of rejoicing into a house of mourning.

I hold strongly to the opinion that labor is a purely physiologic function, and strictly a normal process of the organism. There is no such thing as unnatural labor, and I am entirely opposed to that mental attitude which would divide presentations or deliveries into those which are natural and those which are not natural. Given certain conditions, certain contingencies must arise, but even the most difficult and complicated labor is still a natural one. It is true, however, that the conditions attending the parturient state may be those which we recognize as being the most favorable to the expulsion of the child, or, on the other hand, various obstacles may be encountered which more or less interfere with delivery and produce difficult labor. A logical division, therefore,

would be into, 1, ordinary or uncomplicated labors, and, 2, exceptional or difficult labors.

With regard to the first group, which comprises more than nine-tenths of all the cases, the present teaching of obstetric science is simply to secure cleanliness and to interfere as little as possible. Many a normal case has been converted into a pathologic one by too frequent digital examinations, especially where the examining finger has been the bearer of infection. Many a natural labor has been complicated by lacerations, owing to the desire of the attending obstetrician "to hurry things up" so that he could get off to keep some other engagement not always professional. Many a physiologic parturient process has been rudely checked and converted into a pathologic one by the over-zealous attentions of a physician who seems bent on demonstrating the truth of the old aphorism, "Meddlesome midwifery is bad." In the majority of cases nature is perfectly competent to accomplish the delivery of the mother without assistance.

Just consider for a moment the logical import of the teaching that a woman after confinement is in the same condition, as a case of amputation with a supposed infectious wound, and that blood-poisoning will develop unless vigorous antiseptic measures are taken to protect her from it. If nature had, with inconceivable malignity, laid a trap, from which there was no escape for any parturient woman, unless the antiseptic art of the obstetrician should release her, how could the human race have survived all these dangers, while waiting for the doctrine of antiseptics to be developed and carried into practice? If these precautions and attentions are necessary in every case, how is that savage races with their rude midwifery methods do not perish from the face of the earth? When I practiced medicine in the State of Louisiana, a woman stopped and spent the night at my house who had been captured by the Comanche Indians with her husband and two sons. The husband and sons were killed in her presence. She lived for three or four months with the Indians and, during this time, she was pregnant and miscarried at the sixth month, while in captivity. She told me that the Indian women marched with their husbands until they were taken in labor, and then they were helped to the nearest pool of water. As soon as the child was born it was plunged into the cold water. If it struggled vigorously it was allowed to live, if not it was drowned. The mother also went into the cold water as soon as the after-birth was thrown off. The child was then strapped upon her back and she followed the tribe and resumed her work as if nothing unusual had occurred. The point that I make is not that this is the best treatment for the lying-in patient, but it is that, even with the neglect of everything that we regard as essential, nature does the work and the great majority of mothers actually do survive the perils of childbirth.

I am also strongly opposed to the resort to instru-

mental delivery merely to suit the convenience of the physician. Now, I do not want to be misunderstood. I look upon the forceps as the most humane of instruments, and do not stand aside and hesitate when they are to be used in the interest of the mother or child. Some years ago, by invitation, I went to hear my friend, Dr. Albert H. Smith lecture before the Philadelphia County Medical Society on the use of the forceps, and in the discussion of the paper I expressed my disappointment, and said that "I had come up to learn when not to use the forceps." He thought that the forceps should be used whenever there was the slightest delay to the passage of the child in the second stage of labor, that the patient should not be allowed to suffer. It requires good judgment to recognize when to refrain from using the forceps. There is oftentimes too much haste to resort to their powerful aid; traumatism may be thus produced, and a dangerous chain of consequences be initiated. My conviction is that the obstetrician has no right to consider himself at all, but only his patients, in the process of labor. In other words, I would state the duty of the obstetrician, in attending a case of normal unobstructed labor, is to be summed up in the words "cleanliness" or "asepsis." He should be on the alert, ready to render assistance should occasion arise, but otherwise he should practice a policy of non-interference. I believe the old country doctor, who boasted that he had never used the forceps and stated that plenty of good fresh lard and a good deal more patience were all the instruments he wanted, is far safer than many of the present day who seem to feel called upon to use instruments in nearly all their cases. Even at any time in the most skillful hands, there is always more or less danger to the integrity of the soft parts, and when used to save time for the doctor, or magnify his importance, I consider it a crime.

While insisting upon the usefulness of a warm soap and water bath at the beginning of labor and a preliminary douche to cleanse the birth canal, if the patient does not seem to be cleanly, especially in lying-in hospitals, I am opposed to subsequent repeated douching and especially to irrigation of the uterus after labor except where absolutely indicated to overcome an actual septic condition, due to retained placenta, or other cause. Chemic disinfectants are not required to obtain and maintain a condition of asepsis, and their routine use is to be deprecated in the parturient woman. On the other hand, I would commend the practice of rendering the hands of the obstetrician and all instruments used by him, as aseptic as possible by the abundant use of soap and hot water, followed by a rinsing with solution of bichlorid of mercury (1 to 2000). By the universal adoption of this plan of treatment, puerperal septicemia may be eliminated from among the risks of childbirth. By carrying it out at the Preston Retreat and in private practice, Dr. Joseph Price claims that he has not had a case of this character in nearly ten thousand labors. Moreover, there is an incidental advantage by the adoption of this method, which deserves our serious consideration. It is the abolition of ophthalmia neonatorum. Dr. Price has recently stated that infantile ophthalmia has been banished from his practice by the adoption of asepsis in the conduct of labor, and it has been claimed that three-fourths of the blind asylums could be closed for want of inmates, if this plan of conducting the obstetric procedure were universally followed. I have never kept a record

of my obstetric cases, but in a very active practice of forty-six years they have run into the thousands. I do not remember to have had a dozen cases of sore eyes and not a single infant lost its sight. I conscientiously assert that I never lost a patient in labor, or as the result of labor. I do not say this in a boastful spirit, for I feel that I have been more blessed than skilled, but I say it because it is a fact, and I think my scrupulous regard for cleanliness has had something to do with it.

During the past year, a law has been very carefully framed by a committee of this society and has now passed the legislature, which has for its object the prevention of blindness. It makes it incumbent upon midwives, obstetricians and health officers to see that an infant with sore eyes shall receive prompt attention, in order that its sight may not be lost through neglect. While we thoroughly approve of the humane motive which inspired this legislation and anticipate great benefit from its enforcement, we still think prevention better than cure, and insist upon the prophylactic value of absolute cleanliness in the conduct of labor, as conducive to the best interests of both mother and child.

Just here I want to frown upon the fad of the routine use of anesthetics in labor to save suffering. Who can tell what the effect of these God-given pains, the result of nature's force, may have upon the mental economy of the mother? The use of anesthetics and the hasty removal of the placenta by traction are most fruitful sources of post-partum hemorrhage, and of asphyxiated infants. I do not intend to discuss the medical treatment of the puerperal period; but would simply offer a word of protest against routine. Unless there is good reason to be given, the fluid extract of ergot should remain in the bottle, likewise the castor oil, quinin and the malt liquors. Meddlesome midwifery is bad and so is officious medicine-giving. There is a principle in letting well enough alone and it takes some experience and good judgment to know when to do it. Oliver Wendell Holmes, in speaking of the abuse of physical diagnosis, said that some patients "are done to death with the pedantic foolings of the specialist," and the remark applies with peculiar force to midwifery practice. In connection with this subject as a collateral branch, I may refer with commendation to a recent communication to the Philadelphia County Medical Society by Dr. W. Reynolds Wilson on the treatment of ophthalmia neonatorum by irrigation with distilled water.¹

It is gratifying to note that with an increasing familiarity with the conditions of delayed labor, there have been devised methods which are favorable to the preservation of the life of both the mother and the infant and that the dreadful alternative involving the sacrifice of human life by craniotomy is now rarely presented. In case of eclampsia at term and also in the condition of placenta previa, requiring rapid evacuation of the contents of the uterus, I must speak in terms of high commendation of the method of rapid manual dilatation and delivery devised by Dr. Philander A. Harris, of Paterson, N. J., first described in the *American Journal of Obstetrics* last year.² In a discussion of the subject of "accouchement forcé" before the Philadelphia Obstetrical Society, Dr. Harris recently reported³ his entire experience with his

¹ Medical News, April 13, 1895.

² Vol. xxix, p. 37.

³ Annals of Gynecology and Pediatrics, Vol. viii, p. 476.

method in placenta previa and eclampsia, and stated that in all cases in which there were no labor pains or partial dilatation of the os uteri before he attempted delivery, he had not lost a single case. This certainly marks a great advance over the older methods of treating these great complications of pregnancy.

Since the introduction of aseptic methods of operating an expedient in cases of contracted pelvis devised over a century ago, by a Frenchman, M. Sigault, symphysiotomy has been revised, and is being largely practiced with increasing amount of success. An able paper on this subject was read at the last meeting of the Society by Dr. Horace Fox, of Philadelphia. Dr. Robert P. Harris, of Philadelphia, the well-known statistician and recorder of the Cæsarean and Porro operations, is now enthusiastically in favor of symphysiotomy, the mortality of which according to the authority in the last seventy-five cases has been less than 10 per cent. In one of the recent cases in the State of Washington a child of fifteen pounds in weight was delivered by this method which only a few years ago might have been sacrificed. Symphysiotomy may be an operation of election or of necessity; the former when the patient is seen during the progress of pregnancy; the latter when the obstetrician is called in to attend the case after labor has been initiated. The simplicity of the procedure as compared with the Cæsarean section, or any mutilating operation, and the brilliant results obtained by it with proper management, certainly warrant its general adoption in appropriate cases. The method of performing the operation is given by Professor Farabœuf as follows:

"The woman is placed in the dorsal position with the thighs abducted and flexed upon the abdomen and held in that position by two assistants. The pubic region is shaved and this, with all the adjacent parts, is washed first with soap and water, then with sulphuric ether and finally with a solution of bichlorid, or of biniodid of mercury (1-2000). The patient is then fully anesthetized, catheterized and a vaginal douche given. The length of the incision varies with the length of the symphysis in different subjects and must be made, vertically, midway between the two spines of the pubis beginning at the level or a little above the superior border of the symphysis and descending to its inferior border, deviating in the neighborhood of the clitoris without touching the superior part of the vulva. Then cut through all the soft tissues down to the cartilage and do not stop to seize any bleeding vessels. Then upon the index acting as a guide, with the scissors divide the fibro-cartilage at the level of the anterior surface and superior border of the symphysis. Then we make two small incisions transversely beginning at the median line close to the superior border of the symphysis in such a way as to cut through the aponeurotic tissues in order to make a passage for the index, which is then introduced along the posterior surface of symphysis. The finger then feels very well the posterior prominence of the fibro-cartilage of the symphysis. Left in this position it serves as a protection to the organs lying posterior to the symphysis. With a straight scapel, begin cutting the cartilage from before backward and from above downward and finish the section by means of a blunt pointed bistoury. At the moment of cutting through the sub-pubic ligament by means of a sound introduced into the bladder, an assistant pulls the urethra out of the way. The incisions,

through the cartilage are kept up as long as the knife continues to creak, for the latter indicates the resisting cartilage and ligaments giving way. The operator feels the structures slowly giving way, and, finally, when all is cut, the iliac bones in a measure separate. The assistants now practice slow and progressive abduction of the thighs. The surfaces of the divided cartilage separate from each other and we are thus enabled to introduce between them one or two fingers, according to the degree of separation. Experience teaches us that no damage to the sacro-iliac articulations can be brought about by a separation of 7 centimeters. The separation can be brought about by the operator himself with the assistance of the *écarteur* designed by Prof. Farabœuf. When that degree of separation which the operator deems sufficient is obtained the assistants must be warned not to move, but to hold the limbs in that position thus attained. A tampon is placed in the wound, and this may be either a sponge, absorbent cotton, or iodoform gauze. The operation being completed, we now proceed to the extraction of the fetus. The extraction of the fetus is done artificially. We apply the forceps according to classical rules, *i.e.*, on the parieto-malar region of the flexed head. We pull and the head easily descends, separating the pubis as it advances, provided the latter separation have not been sufficient. If any great resistance is experienced, we must not exercise too much force, but continue to separate the pubis to the limits allowable. As the head descends transversely in the excavation we must subject it to a rotary movement so that it may pass through the inferior muscular and osseous tracts. Here a most important maneuver, advised by Dr. Varnier, must be resorted to in order to avoid the many injuries to which the anterior vaginal wall is liable in the hands of inexperienced operators. If we examine the vulva and soft parts while the iliacs are separated, we find that they no longer present an orifice, longitudinal from above downward and from before backward, but one which is stretched transversely, with a large transverse axis, and whose superior part now lacks support, since the bones are separated. The head, which has been subjected to the rotary movement above mentioned, now presents its largest diameter longitudinally to the largest diameter of the orifice, which is directed transversely. The head presenting itself in this position, any effort to extract the fetus would undoubtedly produce rupture of the vulva and of all the soft parts, where support is lacking, *i.e.*, where the pubis has been separated. A tear of the anterior vaginal wall is a most inevitable result. In order to obviate this Dr. Varnier advises the following method of procedure which is most simple: When the head has effected its rotary movements the assistants approximate the thighs, thus causing the separated iliacs as well as the transversely stretched vulvar orifice to resume their normal position, and the head as in any normal confinement is delivered without producing any injury to the inferior osseous and muscular straits or vulvar orifice. The operation is now terminated as to its essential parts. The umbilical cord is tied or compressed and divided, after which the new-born child is given to an assistant or nurse. A vaginal injection is now given and artificial delivery of the placenta is performed. The vagina being well packed with iodoform gauze, we next devote our whole attention to the pubic wound. The tampon which was previously placed in the wound is removed and the wound is irrigated with

a 5 per cent. carbolic solution, or biniodid of mercury (1:2000). The assistants approximate the iliacs by continued pressure on the hips, and the operator proceeds to suture the tissues with two or three buried sutures and as many superficial ones to keep the parts in perfect apposition. The wound is then covered with iodoform gauze and antiseptic absorbent cotton. A tight bandage is then placed around the pelvis and this covered over with a second one in the form of a T. A third bandage intended to give support is then applied, and for this plaster of Paris is used. We must apply this in oblique directions so as to leave the pubic region free, and so allow freedom for future dressings. These latter dressings must be renewed very often, at least twice a day, because they are always soiled during micturition. The vaginal dressing may be allowed to remain for two or three days, as it insures the perfect antiseptics of the vagina, and thus we can dispense with the injection which would otherwise be necessary during this period. It is necessary also that the limbs should be immobilized by strapping them together. Of course, under these conditions, it is difficult to give injections, so that it is quite sufficient to wash the vulva after each micturition. About the eighth day the wound has become cicatrized. Often enough you will find that edema of the pubes has caused the sutures to cut through the tissues. These may be taken out at the rate of one or two a day."

Now the merit of this operation is that it saves the child with a minimum risk to the mother. Notwithstanding the operation has sometime to be hurried so as to complete it before the child has been naturally delivered, I look upon it with more favor than the Cæsarean section or craniotomy.

I find that I have dwelt at such length upon the operation just referred to that I have no time to discuss delayed labor due to unusual presentations or positions of the fetal organism. In occipito-posterior position it has lately been advised to manipulate the head before the second stage has begun, so as to convert it into an occipito-anterior position. The change was advocated by Baudelocque, Dewees, Hodge, Meigs and others, Dewees going so far as to say that "a physician was incompetent to practice midwifery in the best manner who could not detect and change the malposition of the head and thus abridge by several hours the misery and pain of his patient." In my own experience I have not always found this an easy thing to do. With present methods of securing asepsis this method of changing vertex posterior into vertex anterior positions should be more commonly practiced, or at least attempted.

In the treatment of many of the mechanical causes of delayed labor due to foreign growths in the uterus or vagina, and in the conditions complicating labor, such as ruptured uterus, hematoma, etc., and some of the sequelæ such as pelvic abscess, pus tubes and uterine sepsis, as much technical knowledge, special training and sound judgment are required as are demanded in any other department of medical science. An encouraging amount of progress toward the satisfactory solution of these many unsettled questions of practice, is shown by the proceedings of our special societies and the pages of our medical journals. The scope of the questions suggested by these topics, goes beyond my present opportunity and I find that I have no time to devote to the consideration of these important problems and the manner in which they are being

solved. I would only make a plea not only for careful diagnosis but also for more individualizing of patients in deciding questions of prognosis and treatment, and not too much zeal for manual and mechanical interference.