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"WHY IS THE ART OF OBSTETRICS SO POORLY PRACTISED? *

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IT is a great pleasure for me to come before you this evening at the invitation of your President. I never think of Brooklyn without recalling several of your very considerable men in my own line of work. I refer particularly to Skene, Byrne and Jewett, to all of whom I am indebted for many things.

I am sorry to say the title of my remarks tonight is not spontaneous, but was suggested to me by your President. I did not know I was going to address the annual meeting of the Society or else I should have put my remarks in writing, so if you will pardon the informal way in which this subject will be presented I shall be happy.

The mere fact that your President has suggested this title to me carries with it the implication that certain people believe that the art of obstetrics is poorly practised. That is open to some discussion, at least, and I know from conversation with many perfectly respectable and enterprising doctors that they all do not hold that view; so I take it if I am to talk to you on this subject it will be obligatory upon me to prove that the art of obstetrics is, as a general rule, poorly practised, and if I succeed, to my own satisfaction, in doing that I shall then consider some of the factors which are responsible for it and possibly lay down certain suggestions which may improve matters in the future.

Now, is obstetrics poorly practised? In the last few weeks interesting statistical proof of this fact has been put in my hands. As you know, the United States Government during the last few years has organized a Children's Bureau which is a part of the Department of Labor. The Bureau is in charge of Miss Julia Lathrop, who is an extremely competent woman and I believe has the unique distinction of being the highest paid female in the employ of the Government. She has associated with her a corps of workers, who, in investigating certain problems connected with children, found they could not proceed with the work unless they studied the mothers, so practically the first thing they have undertaken is a study of obstetrical conditions in this country, and one of her assistants, Dr.

* An informal address delivered before the Medical Society of the County of Kings, Dec. 19, 1916.

Grace Meigs, has just finished an article entitled "Maternal Mortality," which will be distributed free by the Government, and the statements I shall now make mention of are taken from it. She states that in the year 1913, 15,376 deaths occurred in this country from childbirth. Of these 7,000 were due to puerperal infection. The remaining 8,000 were due to the various accidents of childbirth. Of course, that is a very considerable death rate, and her statistics show that when the causes of death in women during the child-bearing period—that is, between the ages of 15 and 45, are analyzed, childbirth next to tuberculosis, was the most common cause of death. She also figured that in 1913 one woman died to every 154 babies born. Accordingly, if we average four babies to a family, this means, roughly speaking, that one woman out of every 40 in this country between the age of 15 and 45—whether married or single—will eventually die in the act of childbirth. This sounds pretty bad, but does it really mean that obstetrics is poorly practised, or does it mean that this represents the inevitable death rate associated with what should be a physiological process?

Dr. Meigs' statistics apparently prove the former. She states that in the last 23 years (1890 to 1913) in the registration area in this country, which now includes about 65 per cent of the entire population, there has been no appreciable change in the death rate from childbirth; indeed the death rate in the last year of that period (1913) was greater than the 23 years previously. To be specific, her figures show that the death rate per 100,000 of population was 15.3 in 1890 and 15.8 in 1913. Indeed, her statistics are even a little worse than that. They show a progressive increase in mortality in recent years; that is, from 1901 to 1905, inclusive, the total death rate per 100,000 was 14.2, of which 6.3 were due to puerperal infection, whereas in the five years from 1906 to 1910, inclusive, the death rate was 15.3 and 6.8, respectively. In other words, in the first and the last half of the last decennium there was an actual increase in the puerperal death rate. At the same time, during the 23 years in which there was no decrease in the death rate from childbirth, a very striking change had taken place in most other diseases. Thus, for example, she shows that in these 23 years there had been a decrease of 170 per cent in the death rate from tuberculosis; 285 in typhoid fever; 185 in infant diarrhea; 520 per cent in diphtheria. This, of course, means that while the diseases under consideration have been combated most satisfactorily, the death rate from childbirth has remained unchanged, and, as said before, this either means that these figures adduced represent the irreducible minimum death rate or they mean that obstetrics is very poorly practised. Now, which of these is true? I assume that the latter is the case, and my reason for thinking so is that in the better class of lying-in hospitals, more particularly those with large material which can be utilized for statistical purposes, we find the death rate reduced to a minimum, whereas outside of the hospitals it is actually greater than is indicated by her figures.

Another very interesting point which Dr. Meigs makes in her article is that the mortality is higher in large cities than in small ones or in rural communities, and that the death rate in the large cities has actually increased in the last few years; thus, for example, in 1900 the death rate in rural communities and small towns was 11.7 per 100,000 and in the large cities 14.9, whereas 13 years later (1913) it was 13.8 and 17.2 respectively. In other words, there has been an

increase in the death rate of 3.2 per 100,000 in the large cities and a smaller one in rural communities. Now, how can we account for this? One would imagine that the death rate would be higher in country districts where there are fewer doctors, the people live further apart, and also because the doctor in country districts is supposed in many instances to be inferior to his urban colleague; but, in spite of all that, the death rate for rural communities and small towns has been lower than in the large cities, and when we consider that this includes not only the cases coming under the care of the general practitioner and the midwife, but also the cases conducted more or less ideally in the large hospitals, one would expect a great difference in favor of the cities, and the reason that this doesn't occur and the reason why the death rate is higher in the large cities, to my mind, can only be due to the fact that in the large cities the practitioner trusts to an amount of knowledge and skill which he does not possess and this works to the detriment of his patients with the result that the mortality is greater than in the rural communities. The only exception in Dr. Meigs' statistics to this general rule is New York City, which, in the last 23 years, has shown a slight but progressive decrease in puerperal mortality, and this she is inclined to attribute to the large lying-in hospitals and to the extension of out-patient obstetrical charities. So much for Dr. Meigs.

I approached the subject of obstetrical education five years ago in an address which I made to the American Society for the Prevention of Infantile Mortality, entitled "Medical Education and the Midwife Problem in the United States." This did not represent merely my personal impression, but was based upon the study of a questionnaire which I sent to the professors of obstetrics throughout the United States. To the questionnaire I got answers from 43 professors representing some of the very best schools, some of the good schools and some of the poor ones and the data were obtained by averaging up the answer to the forty or fifty questions which I asked these men, beginning with their education, then going over their methods of teaching, the lying-in hospitals, the methods of teaching of their school, etc., etc., and I would direct particular attention to two of the questions, namely Nos. 21 and 22, which were as follows:

Question 21, "Do you believe that more women die from infection in the practice of midwives or in that of general practitioners?" and to this 8 replied that they could not answer, 15 replied the physicians, 13 the midwives and 5 equal. In other words, these 43 professors who were kind enough to answer my inquiries were almost equally divided as to whether worse results were obtained by midwives, who are notoriously ignorant, or by doctors, who are supposed to have some expert knowledge on this subject.

The answers to the second question were even more striking: "Do as many women die as the result of ignorance, or of ill-judged and improperly-performed operations in the hands of doctors as from puerperal infection in the hands of midwives?" Eight could not answer this question. Six answered against the midwives, 26 against the doctor and 2 that the results were equally bad in the two classes. In other words, in this inquiry these men, who had no particular interest in the matter I had in hand, answered that the doctors kill far more patients throughout the country by ill-judged operative procedures than do the midwives by puerperal infection. The result rather surprised me because I didn't expect the answers to come in quite that way. My own experience is very much the

same and from my 28 years' experience in the practice of medicine and 25 years' experience in teaching I have come to the conclusion that in Baltimore at least the ordinary doctor does more harm to his patients, as a rule, than the midwives, although we surely know that the midwife does a great deal of harm. You know in the Bible there were two midwives, Shiphrah and Puah. They were the two midwives whom Pharaoh instructed to go out and kill the little Hebrews as they were born, but they didn't. It says further on in the Bible that God was good to the midwives. I think he has been extremely good to them ever since and a great deal better than they deserve. We all admit that they do a great deal of harm, but the harm which they do is exclusively in the way of puerperal infection. (At this point the doctor said that while the physicians not only get as much infection as the midwives, they do the most harm by interfering with conditions which should be left alone and that they frequently convert an apparently simple condition into a complicated one. Continuing, he said):

Now, that is rather a railing accusation, but I have had considerable experience and I have had a great many patients brought into my service after being handled by doctors, and my general conclusion is—I am talking now of Baltimore—that the ordinary run of doctors haven't a clear conception of what asepsis means.

Another very striking thing I have observed is that the ordinary doctor hasn't a very clear conception between the first and second stage of labor. He doesn't know that the child doesn't begin to descend until the cervix is fully dilated. A considerable proportion of my consultation work consists in being called to see a woman in the first stage of labor with the request to deliver her when all that is necessary is to give nature a chance. In a large number of these cases I am called in after the doctor has interfered and he has interfered on an erroneous diagnosis and done something which he shouldn't do, but the two things which I find are most abused are:

First, manual dilatation of the cervix to hasten labor for one reason or another, and

Second, the application of forceps in mistaken diagnoses, and a common mistake is for the doctor to make a diagnosis of L. O. A., where in reality he has to do with an R. O. P., put on the forceps incorrectly and then attempt delivery by brute force, with the result that many children are born dead and not a few of them with fractured skulls.

While speaking of dilatation of the cervix, I cannot help telling you a story which one of my associates told me the other day. I asked him about his experience in consultation work in connection with dilatation and he replied, "Did I ever tell you about the experience which I had last summer in one of the suburbs?" I replied that he hadn't, whereupon he said, "I was asked by a doctor to help him in a difficult case. I went out to the house and the doctor told me that he was in an awful predicament, as he had attempted to dilate the cervix, but was unable to do so, and he said, 'See what you can do.' I examined the woman, found a frank breech presentation with the cervix fully dilated and the breech just inside the vulva and I readily extracted it," but, when he came to examine the child afterwards the anus looked like the metaphorical star with rays extending in every direction.

I don't want to go on with this catalogue of horrors, but really

one has some remarkable experiences. One day in a street car I met a very estimable gentleman and he said, "Dr. Williams, I am going to a very interesting case." I said to him, "Is that so, what kind of a case is it?" "I am going," he said, "to do the sixth consecutive craniotomy on the same patient." "What are you going to do it for?" I asked. "Why, she has a contracted pelvis." When I replied that that was not a satisfactory indication, he said, "I think it is a very good reason." "Well," I said, "I consider you a blankety blank murderer," and he got up and sat on the other side of the car and hasn't spoken to me since.

Furthermore, when you think of the way that the woman in the lower walks of life is handled and what she gets in the way of obstetrical treatment when she employs a private physician you can't blame her for going to an obstetrical dispensary. Of course, the doctor may feel that because of the smallness of the fee which he gets from such women in childbirth, he does more than he is paid for, and he may be right, but when that woman hears of the prenatal care and the excellent service at the time of labor and during the puerperium which one of her friends received from a well-conducted obstetrical dispensary, can you blame her for going to the dispensary when she is pregnant again and for feeling she has had a pretty raw deal in the meantime.

I have just picked out these various points at random and could go on indefinitely. Don't misunderstand me. My accusation does not hold against all general practitioners, because I know numbers of them who are excellent, competent, conscientious obstetricians and in whose hands a patient is extremely safe. What I have given you are merely examples of some of the things which one sees.

Taking, then, into consideration what I have quoted from Dr. Meigs' article, the replies to my questionnaire of some years ago, and the other things which I have referred to, I think I have pretty fairly proved that there is considerable abuse in the practice of obstetrics and I think Dr. Pomeroy's question, "Why is the art of obstetrics so poorly practised?" a perfectly justifiable one.

Now, I think I can conclude that, as a rule, the only people who get thoroughly first rate obstetrical care are the well-to-do, who employ a competent specialist, or the very poor who have sense enough to go to a hospital for delivery. The great mass of people in the self-respecting lower classes get, in my opinion, very poor care. Of course, some of them get excellent care, but the problem before us is not how to care for the well-to-do rich, or the poor woman in the hospital, but how is the woman in the middle walks of life, the woman who with her husband forms the backbone of our population—how is she to get proper care at the time of labor, and how is her family to get proper care in any other medical emergency? Of course, I wish only to touch upon the obstetrical side of the question.

Now, what is the cause of this defective practice of obstetrics? That is a very difficult question to answer, but I am inclined to attribute it to three main factors:

- First, defective medical education.
- Second, lack of special training, and
- Third, the indifference of the laity.

What do I mean by defective medical training? Everybody who has studied obstetrics in this country got a very good course, no matter how long ago it was, from the standpoint of oratory. Ob-

stetrics is one of the easiest branches of medicine to teach. The reason for this, Dr. Williams said, was because it is a branch of medicine that can be covered reasonably well in an ordinary course of time, and that as far as the teaching went it had been sound, and that the defects in obstetrical training had not been from an oral standpoint, but rather from the lack of inspiration. He did not feel that this would be welcome until a different type of teacher had been developed, who would be able to impress the students with the fact that he is not only capable and is cognizant of the practical side of obstetrics; that he is not only a good man midwife, but a first-class scientific man who looks beneath the surface; and who is able to impress his students with the fact that obstetrics is a scientific study; and that there are two important things to be considered, namely, "finding out and learning how;" and that there are "very few obstetricians in this country who find out anything or learn to do anything which somebody else hasn't done before." Continuing, the doctor said that our information on this subject has come almost entirely from abroad and that he thought this was the fundamental defect in obstetrics in this country.

The doctor then took up the second point which he felt contributed to defective obstetrics, namely, lack of special training, and said:

"We think that because a young man serves in a hospital as an interne for a few months or even a year that he has learned a great deal. He learns something, it is true, but it is very little, and it is my experience that an interne after one year's stay in the hospital is only useful for his hands. He has another pair of hands which you can direct sometimes, but he is only useful as something to work with. As for his knowledge, it is extremely little, and as for his diagnostic ability in a complicated case it is almost nil." At this point the doctor said that, in his experience, it requires at least a year's training in a hospital to initiate an assistant into the practice of obstetrics and that if he wants to learn to be competent to treat complicated cases it is a matter requiring several years, and he thought three years should be considered as the minimum.

"Another cause of defective obstetrics, to my mind, is the lack of appreciation of obstetrics by the layman. The ordinary person in this country regards childbirth as a perfectly normal procedure and that one man can supervise it as well as another. That is the only explanation for the persistence of the midwife in this country.

Now, the question is this: How can we improve these conditions? That is the hard part. The first way, and I take it the only way, by which we are going to improve conditions effectively and permanently is by a radical change in the general character of obstetrical teaching. What we need in this country are men who regard obstetrics as a scientific career and one in which they can put their entire efforts, and we should teach our students that the things that men see and learn are in the hospital and in the laboratory and not in the size of the fees which they will collect later on. That is the first fundamental. I don't believe we are going to get that in this country until our doctors and obstetrical schools greatly change. I think we are eventually going to get in all first-class medical schools thoroughly well equipped clinical professors who are not only skilled in the care of patients, and in the ordinary methods of instruction, but who are prepared to devote the remainder of their time to productive research work.

In my article upon obstetrical teaching, one of the first questions asked was concerning the special training which had preceded appointment to the professorship of obstetrics, and I was very much astonished to learn that a number of them had no training at all. Two or three said they never saw an obstetrical case until they became professors and a large number hadn't seen more than a hundred cases. Those times have passed and I think that in another twenty-five years we will be teaching in this country a totally different type of obstetrics. When I graduated in medicine my obstetrical training consisted of but a single case of a colored girl up an alley with eclampsia, and many of you doubtless have had the same experience.

You may perhaps be surprised to know how modern the clinical teaching of obstetrics is in this country. At a gathering of some prominent gynecologists from different parts of the country about twelve years ago at the New York Academy of Medicine, I asked what contribution had been made to medicine by Dr. James P. White, of Buffalo, to justify the placing of his bust in a prominent situation in the New York Academy of Medicine. No one present knew much about Dr. White or his work with the exception of Dr. Matthew D. Mann, who was Dr. White's successor as Professor of Obstetrics at the University of Buffalo. Dr. Mann informed us that Dr. White was the first man in this country to deliver an obstetrical patient before his students, and that was in January, 1850. He delivered an Irish girl before his graduating class and it created such a sensation in Buffalo that the newspapers took it up and the criticisms which arose as a result of it became so acute that he felt called upon to sue one of the papers for criminal libel. That did not end the matter, however, as it was taken up by the rest of the country. During the trial, the evidence in which was voluminous, one gentleman from New York State, said one did not need to see anything in obstetrics, that it was all the sense of touch and you didn't need much of that.

I thought it might be of interest to read you some of the things said about Dr. White. It appears that after the trial, in which he lost out (it was really a Scotch verdict), a letter appeared in the July number of the American Journal of Medical Sciences for 1851 (N. S. XX, 445-51), signed "C. M.," at first believed to have been written by Charles Meigs, Professor of Obstetrics in the Jefferson College, of Philadelphia, but later it was found that Caspar Morris was responsible for it, and before criticising Dr. White in numerous ways, it went on to say:

"Some months since we heard references to the excitement which had been created among the people of Buffalo by an attempt on the part of the Medical College established in that city to introduce 'Demonstrative Midwifery' into their course of instruction. Having ourselves enjoyed the benefit of such instruction while a pupil, knowing that it was still afforded to students of this city, and accustomed to esteem it as highly important, we were not a little surprised to find it considered a novelty anywhere, and yet more to understand how it could be made a subject of popular odium. When, however, we came to be apprised that the improvement consisted in subjecting the process of parturition to ocular inspection in one of its stages, our surprise at the excitement yielded to astonishment that any teacher of the obstetric art should suppose it could be made the subject of the sense of vision, and mortification that the medical profession should have been placed in a position so well characterized to array public

feeling in hostility to it. We have never understood the full details of the case until we read the report of the trial and the testimony of the witnesses, etc." In the latter part of the article the writer inveighed strongly against such a practice, and said that were students to become accustomed to ocular instruction, they would, to a great extent, lose their delicacy of touch.

In the following number of the same journal (1851, N. S. XXI, 270), a second editorial appeared upon the subject, in which it is stated that, having received a letter from Professor White in reference to his supposed neglect of the patient, the editor willingly retracted everything which reflected upon Professor White's medical treatment of the case and admitted that "the language of the reviewer was too strong," but, after having made these admissions, he concluded:

"These we consider, however, as points of secondary interest—of importance only that injustice may not be done to individuals—they leave the main question, the propriety and advantage of 'Demonstrative Midwifery' as practised in Buffalo, unaffected. Respecting this, we must concur with the reviewer in all that is said of it, both as a means of furnishing instruction and on the score of expediency and propriety. And these sentiments are not confined, as is supposed by some, to a small minority of the profession. We have yet to meet with a single respectable physician of Philadelphia who does not concur with it; indeed it is, so far as we have been able to learn, the unanimous sentiment of the profession of this city, and if we may judge from the sources of our information, that of a large majority of the profession in the United States."

The discussion did not end with mere newspaper comment and editorials in the medical press, but it was referred to the Committee on Education of the Medical Association, one of the members of that committee being James A. Wood, of New York. In its report at the Charleston, S. C., meeting of the Association in May, 1851, this committee said that it was altogether wrong and that it wasn't necessary to show the student anything at all; and in this connection it might be of interest to state that during the course of the trial one of the physicians, who testified in opposition to Professor White, stated that quite as accurate a conception of the distention of a woman's perineum in labor could be procured from comparative anatomy as from the living subject! As if all that it was necessary to do was to take the student in the spring of the year out to the barn enclosure and have him witness the parturition of a calf and this would be sufficient to qualify him for a Diploma in Midwifery and he would then know how to support the perineum; or if he be somewhat obtuse, why, let him observe with attention the distention of the perineum when the hen lays her egg, and then he will be complete in his studies by the rule of comparative anatomy.

At this juncture the doctor stated that that was the condition of affairs sixty years ago and that he would leave it to his audience to decide the point as to whether any considerable progress in the teaching of obstetrics had been made in that time; and that he was not a pessimist, but rather an optimist. Continuing, he said:

"The education of the laity is going on in a very striking way and I don't think that most people appreciate what is being done. The Children's Bureau, of which I have spoken, is doing a great deal to educate the American women at the present time. In the City of

Baltimore they studied all cases of obstetrics in the year 1915. They started on January 1st and visited over 15,000 women who had had babies in Baltimore a year ago. They are studying this from every point of view and they are, first of all, going to try to find out how many babies were born and how many were alive one year after birth and in the cases of those that died what they died from. What is of particular interest to me is the fact that they are making a statistical study of the attention these women received at the time of labor. They are not going at the thing superficially, but, on the contrary, are going into the homes, and interrogating every woman as to the treatment that she received. They are going to divide it into four groups, 'Satisfactory,' 'Good,' 'Poor,' and 'Bad,' and when those statistics are forthcoming I think a very interesting weapon will be put into the hands of the women in this country and they will be apprised of the fact that it is possible for them to have better obstetrical treatment than they have been getting, and while I have no knowledge of what they are going to say, I feel they are going to say that in order that the treatment shall be considered satisfactory a woman must have had her urine examined at least six or seven times during the pregnancy, and a month before labor must have a thorough preliminary examination, not merely an obstetrical examination and mensuration of the pelvis, but a general physical survey as well. Furthermore, the matter of prenatal care will be taken up in great detail, and great good and a great amount of information will be obtained which we have never gotten before. Just a day or so ago a woman came to see me and said she had been made Chairman of the Committee on Obstetrics of the Mothers' Congress and of the Federated Women of America; that these organizations maintained a journal which has a circulation of I don't know how many thousands; that one page of each number had been set aside for the purpose of bringing before the women of America the problems of obstetrics and she wanted me to write the first page for it. Now, when the lay woman is becoming interested in better obstetrics and when the average woman of the country is going to have this information put in her hands, it is a matter of considerable importance to the average doctor.

"Now, what are the remedies? The remedies are better medical education, longer training for the men who expect to go into obstetrics and the recognition by the medical profession in general that there are two types of doctors as far as obstetrics are concerned, one type which is fitted to cope with any reasonable obstetrical emergency and the other type which is not. One are obstetricians and the other are men midwives, and the woman who wants good obstetrical treatment should go to the former and the woman who wants bad obstetrical treatment should go to the latter. The other point, I take it, is that, in the long run, the average practitioner who has not had a competent obstetrical training should be limited almost exclusively to multiparous women and that the primiparous women should be taken care of by the trained obstetrician or in the obstetrical hospitals. I believe that in the future we are going to see a wonderful change in obstetrical hospitals both for the pauper and for the well-to-do and in the distant future I take it that the first labor of every woman will be regarded as quite as serious a matter as an ordinary surgical operation and that she will no more think of having her baby at the hands of a person who is not specially trained than she would think of going to some-

one without training to have her appendix taken out. I take it that it is somewhat along these lines that the advance in the education of the public is going to occur, and as soon as women learn how badly they have been treated in the past they will demand better treatment and they will go only to such doctors as they believe are properly trained.

"I am sorry to have presented the matter before you in this way, but hope I have made some of the points clear to you."