THE DRUDGERY OF OBSTETRICS AND ITS EFFECT UPON THE PRACTICE OF THE ART, WITH SOME SUGGESTIONS FOR RELIEF

By Brooke M. Anspach, M.D.
Philadelphia, Pa.

TO RECITE the demands made upon the practitioner of obstetrics, that constitute the drudgery incident to the practice of the art, is like carrying coals to Newcastle. For the purposes of this paper, I shall mention briefly only those that seem to be the most distressing.

The uncertainty as regards the time of onset of labor is proverbial. Who can determine in a given case precisely when labor will take place? Although, in a majority of instances, computed by the customary rule, the date can be fixed approximately, a variation of from ten days to two weeks is not unusual. Such variation cannot be regarded as abnormal so long as there is no way of ascertaining precisely when ovulation and conception took place. This uncertainty leads to much annoyance and inconvenience for the patient, her family, the doctor, the nurse, as well as for the management of the hospital, if she elects to go to one, in which she is to be delivered.

It is upon the obstetrician especially that the burden falls most heavily. Thus he finds it difficult to leave town or must delay his going, since some one is always overdue; or if the coast seems clear and he is permitted to depart in peace, an unexpected or premature labor is sure to call him back. And so his plans invariably miscarry, for he is either detained at home, or sent for when he leaves.

As soon as the patient falls into labor, the obstetrician must revise his daily routine to some extent at least, rearranging his visits and his work so as to be able to reach her as quickly as possible, or he may accept the risk of the day's work and trust to good fortune to be on hand when he is needed. In complicated cases there is no choice, for here he must be in more or less constant attendance throughout the entire labor. How frequently it happens, in such cases, that, at the end of an extended period of observation, the best judgment and skill of the obstetric attendant are required to effect a successful outcome, and this, too, at the most inopportune time, when the physician is exhausted and physically and mentally unfit to undertake the work.

It is doubtful whether there is any more troublesome exigency in any branch of medicine or surgery, or one that requires more well-balanced judgment and greater skill. Neither is there any situation in which the physician feels more keenly the burden of responsibility—

the mother and the child, the anxious relatives. It is an undeniable fact that at this time, in order to do his work most successfully, the obstetrician, as well as his nurse and assistants, should be unfatigued.

Upon the obstetric nurse the hardship is in some respects even greater. She it is who spends weary hours listening to complaints, attempting repeatedly to comfort the patient, who, forsooth, cannot be comforted. She must bear the stress of possible operative delivery at the conclusion of this trying period, followed by the immediate after-care. She has two patients instead of one. In private home cases many additional cares are added to her already heavy burdens—the preparation of meals, the laundry, dealing with the servants and members of the family, etc.

As a consequence, many physicians and most nurses dislike obstetrics, and avoid it to as great an extent as possible. It is often quite difficult to persuade a good surgical nurse to undertake obstetric nursing. The number of physicians who endeavor to practice obstetrics is small as compared to those who enter other specialties, and in the nursing field the most skillful workers do not commonly select this as their chosen sphere of usefulness.

What is the result of the unusual demands made upon the time, convenience, and patience of the obstetrician? Does it influence him in his conduct of labor? First of all, it is natural that, in order to save himself as much as possible, so that he may be in better condition to overcome the difficulties that he may be required to face later, the obstetrician may not, during the earlier stages of labor, give his patient the close attention she might reasonably expect to receive. The question here arises whether obstetricians as a class are doing all that is possible, under existing conditions, to alleviate the pains of the first stage of labor. "Twilight sleep" has come and, fortunately, gone. Was there not, however, some little truth, at least, to be taken from it? Would it not be desirable to do a little more than is done usually to ease the sufferings of the first stage, for example, with either morphine and scopolamine, or with nitrous oxide and oxygen, or with all of these combined? And in the second stage, is the obstetric attendant usually at hand to begin analgesia as soon as complete dilatation of the os is accomplished? Does not the patient often wait weary minutes or even hours until the obstetrician arrives? May it not be merely the joy that the pain is over and that another soul is born into the world that keeps some of our patients from reminding us of the pains they have been permitted to suffer and to reproach us for the little we tried to relieve them?

It is not hard to perceive that efforts, conscious and subconscious, are made to remove these difficulties in obstetric practice. The expectant mother grasps quickly at any new plan that will bring on her

labor at the appointed time, that will hurry it along and save her from pain, etc., little knowing or weighing the disadvantage to herself or to her baby. And the obstetrician, no matter how conscientious he may be, is almost tempted to induce labor at a set date, administer stimulants for the pains, and adopt manipulative or operative measures to shorten the period of parturition. But who would have the temerity to declare that an artificially induced, conducted, or terminated labor is as safe for the mother and the child as a normal one? And are we not all agreed that the best plan is to let the obstetric patient alone until some actual indication arises for giving assistance?

This problem, and it is by no means an easy one, of relieving the practitioner of the drudgery of obstetrics, is yet to be solved. We can do no more than formulate plans, and then put them to the test of experience. With this purpose in view, I venture to offer the following observations and suggestions:

While the almost general and universal use of hospitals for obstetric cases has infinitely lessened the drudgery of obstetrics, much is still to be desired in the direction of securing close cooperation between the obstetric intern and the practicing obstetrician. The obstetric intern should not only be permitted, but should actually be trained to examine the women in labor under his care. Indeed, before she enters the hospital, the patient should be made to understand that the practicing obstetrician will call into cooperation with him, the obstetric intern.

During pregnancy the obstetrician should be careful to write a full history and make complete and regular notes of visits and examinations, including the results of pelvimetry, the diagnosis of position, etc., which should be sent to the hospital as soon as the patient goes into labor. These notes, with perhaps a telephone conversation, will give the obstetric intern the information he requires. As a result, he will be better able to look after the patient during the early stages, and will summon the obstetrician when he is needed. In the larger maternity hospitals fresh attendants may be provided throughout labor by a shifting staff of anesthetist, two nurses, and an obstetric intern, every eight or twelve hours.

If the period of labor of a patient continues beyond the time allotted to the staff on duty when she is admitted, the notes made by the first staff may be turned over to their successors. By this plan perfect analgesia throughout labor may be maintained by well-trained attendants who are unfatigued and thoroughly awake to the necessities and requirements of the case. There need be no attempt to hurry labor, unless this appears to be to the distinct advantage of the mother or child. Induced labor will be unnecessary, and if the patient requires skilled operative or manipulative attention, this can be secured from

one who has not borne the stress of the earlier stages, and who is unfatigued and therefore at his best.

An elaboration and possibly an outgrowth of this plan would be the association of several obstetricians, men of approximately equal standing and experience in one maternity hospital. Instead of engaging a particular obstetrician to care for her, the patient would enlist the services of the group collectively, stipulating that she would be willing that any one of them should look after her, the choice depending upon the time of her delivery.

In certain large surgical centers, a patient is not permitted to name his surgeon, the selection being made by the management. The layman is satisfied with this arrangement since he realizes that, after all, it is to his advantage. So, too, the laywoman appreciating that what is done is to her advantage, might grow perfectly content. She might then look confidently forward to securing comfortable accommodations, regardless of when labor begins, to perfectly conducted analgesia, and to the services of a skillful obstetrician at his best. She would be spared the induced labor, the long hours of indifferent or absent analgesia, and the anxiety of waiting for the physician to come. The result to women as a whole could scarcely fail to show improvement. More physicians and nurses would take up obstetrics enthusiastically, and the most important episode in the life of any woman would receive the careful and skillful attention it deserves.

DISCUSSION ON THE PAPERS OF DRS. RUDOLPH W. HOLMES, JOHN O. POLAK AND BROOKE M. ANSPACH

DR. IRVING W. POTTER, BUFFALO, NEW YORK (by invitation).—I appreciate your invitation to open this discussion. I have been very much gratified at the papers and very much entertained by the statistics. I am not sorry that I read my first, second and third papers on version, for I can see a considerable change in the expressions of opinion from observers in different sections of the country, and I am going to continue to read papers on version and to do the operation. I am striving all the time to reduce my fetal mortality since the presentation of my first paper. I have had better results since. I am sure that I will get still better results and so will every one who does intelligent elective version.

Our conditions at home are somewhat different from those that most of you have. We have no large hospital where we can take all of our cases. There is not a hospital in Buffalo that will give me the number of beds I want, consequently I am working in five or six different institutions. That in itself will raise the fetal mortality, will raise morbidity, but things are gradually getting better, and it is gratifying to me to find that men from different parts of the country, after they come to Buffalo and see me at work, have changed their views in reference to my work from those they held five years ago.

It seems to me, that the discussion of these papers must be largely upon the following questions, first, whether or not we have any right to interfere in the progress of a case of labor, whereby we may in any way shorten the duration of that labor in the interests of the mother, to relieve her of her suffering and pain as well as the damage to her soft parts from prolonged pressure, and secondly,

in the interests of the child, in relieving pressure both cranial and body. Have we any right to relieve pain? It seems to me that we have. Have we any right to shorten labor provided no damage is done to mother or child? I think we have.

Granting that we have such right, how shall we use it? Personally, I am opposed to the induction of labor and the use of bags. Bags do not give the obliteration of the cervix desired nor the degree of dilatation of the os that is required. Such obliteration and dilatation must occur from the rearrangement of muscle fibers beginning at the fundus and not from the cervix. Bags also have a tendency to displace the presenting part and allow prolapse of the cord or one or more extremities. My preference in the management of these cases is to do an elective version. By that term I mean to perform podalic version at a certain time during the progress of the labor and that time is at the end of the first stage or early in the second stage, thereby endeavoring to eliminate the second stage entirely or at least the greater part of it. In view of the fact that so many complications arise, is not this method of early version justifiable?

My claims for such a procedure are that patients suffer less pain, are less liable to infection because of the lessened mutilation of the soft parts, have a better involution of the uterus, and a better sense of well-being at the end of the lying-in period. No cystoceles or rectoceles are seen following this procedure when properly performed, and extensive lacerations are unheard of. Neither need one fear hemorrhage.

As to the child, we have frequently observed that it was easier to deliver a larger child by version, than it was by an oncoming head; that the damage to the child was far less apparently, than in prolonged forceps operations; that the children are in as good, if not better conditions at the end of 10 days as to gain in weight and general appearance, than in cases where a prolonged second stage was allowed. Our maternal morbidity is less than formerly and the maternal mortality should be *nil*. The fetal mortality we claim is lowered. Our latest statistics covering our last 1000 cases show a 4½ per cent fetal mortality.

Mr. President and Gentlemen, this is not a fad or a fancy, but a procedure that is allowable in the hands of a properly trained man. These statements are facts and can be substantiated by hospital records.

Surely, with our present knowledge of asepsis, if we cannot invade the uterine cavity with safety in the interests of the suffering woman, then I must agree with Dr. Holmes that obstetrics is a lost art.

DR. JOSEPH B. DE LEE, CHICAGO.—In the first place, I desire to dispose of some of the arguments which my colleague (Dr. Holmes) from Chicago has advanced.

The statistics which he has adduced are some old, some new, mostly bad and useless. Statistics in general are very insecure building stones on which to base judgment. The statistics of Newark should not be applied, even if they are true, to the general practitioner neither should they be applied to this Society. Dr. Holmes is charging windmills in a great many of his remarks.

Let us eliminate from the discussion cesarean section for placenta previa. Let us also eliminate the treatment of eclampsia by active measures. Let us limit it to the five points which Dr. Polak has brought out, and which really are the subjects for discussion.

With one sentence I will dispose of pituitrin. Pituitrin in my opinion is an almost criminal agent if used before the delivery of the child.

Regarding the early expression of the placenta, Dr. Polak is right. The placenta should not be expelled before it is completely separated. If the placenta is in the vagina, usually visible without pressure, but if not visible without pressure, visible by separating the labia, there is no reason why it should not be expelled, and its expulsion by pressure on the fundus will not increase the hemorrhage.

Regarding the so-called prophylactic forceps, a name which I have the honor and perhaps disgrace to have introduced, there are present before me a certain number (how many I cannot tell) who are doing prophylactic forceps right along. Some of them have acknowledged it to me. That is not to their discredit; I consider it to their credit. We must, as Dr. Polak points out, prove that this interference in labor brings good results, and that in course of time we will probably be able to do.

The time has come, and for some of us has long passed, for a division in the methods of treatment of natural delivery into that by the specialist and that by the general practitioner. The women are beginning to realize that they need not suffer the damage of labor, the permanent invalidism and death that their mothers suffered. They have learned to seek expert skill and they are willing to pay for it. Further, they are not willing to suffer the pain of labor, and demand its relief.

Many women are ready to undergo the slightly increased risk of cesarean section in order to avoid the perils and pain of even ordinary labor. I am confident that if the women were given only a little encouragement in this direction, the demand for cesarean section would be overwhelming.

A careful study of one's own cases will show that even natural labor can cause much damage. The damage is mainly in the cervix, the pericervical tissues, the pelvic fascia and the pelvic floor. It is unnecessary to enumerate the many sequelae of these injuries. We cannot deny their frequency and their rôle in the causation of permanent invalidism. In the last two years I have paid particular attention to these damages. One in five mothers has good closure; four have tears or relaxation, though there need not be bad symptoms at present. These come later. With few exceptions, all women show evidence of anatomic damage.

We know that too many babies die in labor, even in natural deliveries, yet when last year I presented a simple and harmless method for saving a percentage of these babies, several of our members criticized the method unfavorably.

Last year I read a paper called "Prophylactic Forceps." In the discussion, our guest, Dr. Eden, of London, condemned the operation. On the same day Dr. Eden complained bitterly of the high mortality of the neonati of his clinic and the large number of stillbirths. Fifty healthy babies, he said, had died in spontaneous normal labor in the hands of his own expert assistants, and he thought something ought to be done about it. I, too, think something ought to have been done about it, and I wonder how many of these full term, healthy babies might have been saved by the prophylactic forceps operation. If I may be permitted to hazard a guess, I would say perhaps 40 of them. However, it was a great concession by Dr. Eden, to admit that normal labor could kill babies, and I am also wondering how he can escape the conviction that natural labor is pathogenic.

I claim that the powers of natural labor are dangerous and destructive in many instances to both mother and child, and that interference by a skilled accoucheur at the proper time can prevent a goodly portion of this danger and much of this destruction.

It will need a high degree of obstetric skill to determine when interference is less dangerous than Nature's own methods, and to render the interference less dangerous, but the first is what we specialists are for, and the second, is what we are being paid to do. There is no question that in unskilled hands, many things that we can do with safety, will prove dangerous and fatal, but this is no reason why we should not do them.

We must not pull obstetrics down to the level of the practice of the general practitioner. We must pull the latter up to our level.

As to one method of interference in natural labor, I can refer to my paper of last year, the prophylactic forceps operation. The objects of this procedure are: 1. To save the pelvic floor and fasciæ from destruction. 2. To save the woman from

exhaustion and hemorrhage, even moderate bleeding. 3. To save the child from injurious pressure or death. The essentials of the method are: 1. Procure complete spontaneous dilatation of the cervix. 2. Use morphine and scopolamine or other narcotics freely in the first stage. 3. When the head has come down on to the pelvic floor, and before the fasciæ have been destroyed and the levator ani pillars parted, incision and forceps delivery. 4. Pituitrin and ergot to save blood. 5. Early removal of the placenta from the vagina. 6. Anatomical repair. 7. Morphine and scopolamine to save ether and produce amnesia of the labor.

I had the opportunity to demonstrate this operation to Dr. E. C. Dudley, Dr. Austin Flint and Dr. Brooke M. Anspach. The two first named were enthusiastic and readily admitted that both mother and child had suffered less damage than in a normal labor. Dr. Anspach may express himself here. I believe many of those present frequently deliver women early in the second stage, but do not publish it.

For Dr. Potter's method of delivery I have no sympathy. His own declared results condemn it. He had 10 fetal deaths from hemophilia, 14 deaths from convulsions, 5 unexplained deaths, in addition to 41 deaths during delivery itself, in 1100 cases. His own published mortality of 1123 cases, including 80 cesarean sections, is about 7.5 per cent of the babies. This is much too great, and these women are paying too high a price for their relief from pain in the second stage. At the Chicago Lying-in Hospital under conservative management in the last 9258 cases we have had a gross mortality of 336, or 3.6 per cent. This includes all premature children after the seventh month, weighing 1000 grams or over; it includes all macerated fetuses (86), monstrosities, and also those children born alive and dying before the mothers left the hospital. There were 228 stillbirths and 109 dying after birth. Only one child died from hemorrhage; 1 in 9258. Dr. Potter had 10 deaths from hemorrhage in 1123. It is well known that injury predisposes to bleeding in neonati. One of Dr. Potter's disciples published fetal mortalities ranging from 8 to 17 per cent. Dr. Potter claims that he has no more or greater lacerations with his version than the ordinary practitioner. This argument has weight against his method of delivery. We must learn how to reduce, we cannot eliminate, the damage of labor.

DR. RALPH POMEROY, BROOKLYN, NEW YORK.—I personally have no definite opinion about this matter. I am trying to learn something at this time, and I have been through certain stages of development that almost call for presentation, because I find myself very curiously in a position among the profession of being a radical among many followers of extreme conservatism, and I do not know exactly how to account for it.

In the first place, some 15 years ago I presented for the first time a dilating bag that created a good deal of commotion. Everybody who understood mechanics thought it would do the thing I supposed it would do very nicely, and that is, expand the cervix, but soon after I had published the matter it was taken up as a method of inducing labor. I was never willing to induce labor with anything except by the usual means, consequently I have had the reputation of inducing labor with an apparatus with which I never intended to induce labor.

In the next place, I advocated one principal kind of incision of the perineum as a prophylactic measure, and I have been accused of cutting everything. My own immediate assistants know that is not true, and that the cases are selected.

With regard to the work of Dr. Potter, I sent my own assistant to see him work, and I repudiate any possibility that I am likely to imitate Dr. Potter. I have a most emphatic and wholesale admiration for the development that Dr. Potter has made in the mechanics and surgical process of podalic version plus extraction, but to revert to the general proposition, the principal point I wish to make is that our units of conservation in labor and pregnancy are not the first born but the family,

and I refuse to follow Dr. Potter to his logical conclusion that every large child must be taken out by a cesarean section, because it will not be easy or safe to take it in any other way.

With reference to delivery by cesarean section, Dr. Potter has done it on one of every 13 cases. In other words, there are 18 deliveries by cesarean section in his report of 1000 cases. It is a perfectly logical thing to do if we think of obstetrics in the extreme cases as well as in the moderate and in the minor. Does this assembly accept the proposition for one minute that safe obstetrics is midwifery obstetrics? Of course, it does not. The trouble with obstetrics is that we know a whole lot about it and are just as much entitled to have progressive radicals in trying to see what can be done with serious problems as the surgeons have, because this is a major subject in surgery.

Dr. Potter should be honored, and Dr. De Lee should be honored, as well as others, who have published books on obstetric surgery, for their enterprise. But who practices our obstetrics? Midwives, trained and untrained, students trained and untrained, and interns, all amateurs, most certainly should receive training in this regard, and perhaps a few of us who practice obstetrics. There are not enough obstetricians to go around. The individual woman knows what she wants, and Dr. De Lee and Dr. Anspach have indicated that very clearly, but Dr. Anspach should remember one point, that he will never get any woman to be cared for at his invitation or agreement. She selects her obstetrician as she selects her bridesmaids. In other words, pregnancy and labor is a social event and not a physical event. The woman wants to get away with it with safety and comfort, and with no actual damage, and she hopes there is some one who can carry that out.

My experience is that the only way we will ever solve this problem in an institution of magnitude is by being residents in the institution, one relieving the other every twelve hours, and then we may slip up if we do not have a system by which every item of fact is exchanged in connection with the case when a new man comes on. In cases of prolonged labor it is much better to work in relays rather than adopt the mental attitude and mental picture of the surgeon who is trying to see a case through from one end to the other.

In connection with the statistics given by Dr. Polak and Dr. Holmes, the one thing to be brought out is that obstetrics is not practiced as it is known. In other words, the execution of our work is not up to the standard of our knowledge, and it is extremely difficult to make it so.

DR. PHILANDER A. HARRIS, PATERSON, NEW JERSEY.—I wish to speak from the standpoint of the psychology of Dr. Holmes' statistics as presented to us in his very elaborate tables and in his very extensive review of cases. He referred to Newark; I live near Newark. He spoke of better recoveries and a less mortality in the hands of midwives in Newark than among members of our profession. I think it would be a mistake to publish that statement in a report of our proceedings or in a medical journal and let it go broadcast, because this information would be placed in the hands of a lot of people who belong to the extremely radical elements of socialism.

We know that industrial health insurance has to be fought out in almost every state in the Union. The New Jersey Medical Society this winter spent a tremendous lot of time on this subject, and some of our best physicians went to Trenton for weeks to see the representatives of the legislature, and what for? To prevent having industrial health insurance put over in New Jersey. At the same time, they had two other duties to perform. They had to work to prevent osteopathic practitioners from getting a full board of examiners, so that they could follow their kind of practice in New Jersey.

I sincerely hope that when Dr. Holmes publishes his paper, he will keep in mind

that the midwife, as I understand it, does not have any deaths. When her cases are bad, they fall into the hands of others, who make out the death certificates, and Dr. Holmes should revise or rearrange that part of his statistics which will show this. It is of great importance that this be done now, because unless his statements are corrected or modified, they will be the first thing we will hear about in the legislature this winter.

DR. EDWARD P. DAVIS, PHILADELPHIA.—Spontaneous delivery is not without injury. Concerning the discussion this morning, it points very clearly to our condemnation of two things. First, pituitrin before the child is out of the uterus is dangerous. Second, I am glad to know we have learned that a dilating bag cannot dilate the uterus successfully because it does not favor retraction of the cervix uteri.

We must first consider the good of our patients, which should be the first aim, and then the good of our profession. Dr. Potter and Dr. De Lee illustrate what skilled specialists can do. Other men devoting the same time, with very similar lines of research and practice, will do as well. What is the profession to do? I would speak as a teacher who is accustomed to addressing men who are shortly to become practitioners. This is my expression to the senior class: I hope that few of them will undertake major obstetric operations; that such operations should be done by specialists only, and I do not believe in making serious obstetric procedures attractive or apparently easy for the graduating student. The graduate student should be taught carefully the signs of normal labor and its mechanism and the physiology of analgesia and anesthesia in normal labor; delivery of the patient by spontaneous parturition, the immediate closure of lacerations; the methods of asepsis and, when a normal labor is attended with difficulty, it is time for expert skill. The profession should stand firmly on that ground and the public should be educated to that point of view, and not until then will there be a substantial improvement in obstetrics. I deny absolutely that the best operators in this country are doing wrong in spreading the doctrine to apply skill, intelligence and judgment toward terminating the sufferings of mothers and saving infant life. I do not believe that for one moment. Great advances have been made in the treatment of toxemia and in obstetric surgery, but the latter must be done by obstetric surgeons, and I do not believe any recent graduate can so denominate himself justly and rightly.

Furthermore, we still lack in this trial two important portions of evidence. You have heard the claimants present certain statistics. The statistics of pediatricians and neurologists must also be brought forward, which will tell us how many infants have epilepsy or deficient mental development. Let them report these conditions, and let us know how many of these cases, where epileptic convulsions or deficient development followed, occurred after spontaneous parturition. In the second place, the statistics from the gynecological clinics should be presented, showing how many patients required a secondary operation for repair who were delivered by obstetric surgeons. Then we will be able to come nearer the truth.

DR. WILLIAM S. STONE, NEW YORK CITY.—I cannot refrain from expressing one thought in this discussion which I regard as a most important review of obstetric therapeutics; and I am particularly impressed with the expression which Dr. Polak used which, it seems to me, goes to the basis of the whole thing, that is, intelligent, aseptic expectancy. I regard that as the basis of teaching, and that upon that principle a man should be taught to carry out obstetrics, but who is going to do that? I am quite sure that the expectancy part makes it an impractical thing for any of the men assembled in this room, except the experts in obstetrics, to carry out, and Dr. Anspach suggested something in the way of a remedy.

I would like to call your attention to one thing as I have observed obstetrics develop in New York. We do not really have consulting obstetricians. Our obstet-

ricians are professors of obstetrics, they take cases of obstetrics themselves, and the result is that I do not believe that men who are so busy can carry out all the knowledge which we have of obstetrics. In other words, in medicine we have consulting medical men who do not take cases of pneumonia themselves or typhoid fever cases, but they come in as real consultants. It seems to me, there is a field to be developed here, and that for those of us who are skilled obstetricians to limit our work and to give the benefit of our experience in the way of consulting work, and then our teaching will be based upon the principle that Dr. Polak has suggested.

DR. GEORGE W. KOSMAK, NEW YORK CITY.—I am rather astonished at the character of the statistics brought forward by Dr. Holmes, and I think very likely I express the sentiment of wonder in the minds of a great many of us here at the advisability of bringing them forward in a discussion of this kind. These statistics on the various abnormalities of pregnancy and labor, which refer to observations made 50 or 100 years ago, I think are hardly a fair basis for comparison because at that time the standards were different. There were a great many conditions then accepted which we would not accept at the present day, such as puerperal fever. I think almost every pregnant woman, during the first fifty years of the last century who went into labor, expected to have puerperal fever, and for that matter they felt that labor would necessarily last a considerably longer time, especially in a first pregnancy. It is hardly fair to accept the statistics of the earlier writers in comparison with what has been accomplished during the past few decades.

I believe that Dr. Holmes is entirely too pessimistic as regards the obstetric situation, and that we are warranted by the accomplishments of the last few decades, in assuming a more optimistic attitude.

I desire to refer also to the remarks made by Dr. Harris which I had hoped he would develop somewhat further. Gentlemen, we are facing a rather serious proposition as obstetricians because our state of mind is going to be very much shocked within the next few years by the efforts at reform by lay persons, methods that will not be based on medical facts and on medical experience, but on sociological experiments. You will have brought before you at the executive meeting of this Society a report by the special committee appointed last year to consider this subject of maternal welfare in a broad general way in connection with other committees from other societies. I hope you will bear in mind the discussion today when you consider that report. Specifically, I desire to refer to legislation now pending in Washington in the shape of the Sheppard-Towner bill which on the face of it is one of the most radical steps to which we as medical men have been asked to subscribe. It will practically take out of the hands of the medical profession the care of pregnant women and children, and place their observation in the hands of lay persons, not to be solved as a medical but as a sociological problem.

DR. FRANKLIN S. NEWELL, BOSTON.—There seems to be one point that has not been brought out in the discussion so far. I will say my own personal bias is in favor of Dr. De Lee's prophylactic use of forceps, but when it comes to the question of how every woman should be taken care of, we must study the needs of the individual patient. In the first place, one woman can be delivered with little or no anesthesia in spontaneous labor without any ill effects, while the next woman must have labor shortened, or she will suffer mentally or physically as a result of it. Some women are better delivered by version. To adopt any standard routine and say that a woman must be delivered by a certain method is unintelligent obstetrics. In regard to analgesia I believe that nitrous oxide reenforced by morphine or scopolamine, if needed, is the most valuable method of making labor easier for a woman. In delivering my patients I have nitrous oxide started when the patient feels the need of relief. Patients do not want the anesthetic postponed until we are convinced that they must have relief.

One other point I wish to bring up is that I do not believe in the induction of labor except for cause. If a patient needs to have labor induced, that is a different matter, but to interfere with normal pregnancy for no cause seems to me meddlesome and pernicious. I feel very strongly that most postpartum hemorrhages are due to unwise interference in the third stage of labor, and the longer the placenta there is left *in situ*, i.e., until complete separation has taken place, the better the results for our patients.

DR. ROBERT L. DICKINSON, BROOKLYN, NEW YORK.—This discussion sharply differentiates between the expert with his hospital experience, such as Dr. Polak has demonstrated, and the general practitioner who must take care of the bulk of cases, and the midwife who must take care of the foreign population.

Medicine is proverbially myopic. We refuse to see what the social workers see; therefore, the social worker has got busy and has proposed a remedy. What do we do? We try to thwart it.

The Sheppard-Towner bill is not what we prefer or favor; therefore, instead of taking half a loaf, we refuse bread. We refuse appropriations if the money does not go where it belongs. If it is not done by the state, it is helped by the nation, therefore it is bad legislation and we will refuse it.

Again, we have the name of not being progressive. We must welcome these statistics, however bad they are in form, on prenatal care. The President and apparently the Senate are feeling the pressure of popular opinion brought to bear on a measure which we are not in touch with. We teachers, we professors, are disappointed. I confess myself I am one of the most disappointed men that ever stood on his feet in such an assembly. For nearly twenty years I have tried what little I could do to leaven the mass of the obstetric work of the general practitioner, to raise that level. Gentlemen, whatever progress we have made in our maternities, we have failed to raise that level. Let us then in God's name welcome any outside help, however mistaken, for social health insurance and all that are inevitable. We cannot stop it.

DR. J. WESLEY BOVEE, WASHINGTON, D. C.—A great many years ago we had a definition of obstetrics by Dr. Goodell, "a fellow feeling for a human being." We have seen it emphasized here today I think to an alarming degree.

I want to speak, however, in opposition to the plea suggested by Dr. Pomeroy and of Dr. De Lee of treating patients as they wish. I hold that a patient should be treated as judgment dictates; that we should act as practitioners of medicine instead of those who cater to the wishes of our patients.

DR. JOHN A. MCGLINN, PHILADELPHIA.—Not long ago in this Society, I remember it was considered criminal to stick a hand into the vagina, although it was gloved. We had to stick the finger up into the rectum. Cesarean section should hardly ever be performed unless total hysterectomy was done. Still at the present time, in cases of normal delivery we have to do podalic version to get the whole arm into the uterus. To shorten the pains of the second stage of labor, we have to split the vagina and put on forceps, and these advances are good things.

So far as obstetrics is concerned, it is the same as any other problem in medicine. There is a good deal in common sense. You cannot lay down any hard and fast rules how to deliver every patient. You have to individualize, and these problems are individual. Prophylactic version may be the ideal thing in a certain case. Central episiotomy may be the ideal thing in a certain case, but podalic version is not an ideal thing in every case, nor is prophylactic forceps an ideal thing in every case, or central episiotomy. Certain cases will go through spontaneous labor without difficulty, and our problem is to recognize when cases are not normal and apply the proper remedy with our art and skill, whatever remedy that may be.

DR. N. SPROAT HEANEY, CHICAGO.—I take it that we, the audience, are to be the judges in this presentation of briefs, and since the evidence does not all seem to be at hand, I wish to ask for information.

The advocate of one procedure says that the cervix should not be interfered with in any way during the natural process of its dilatation and places all the importance upon the avoidance of laceration of the pelvic floor. Why is the pelvic floor so important while the cervix is unimportant as far as its injuries are concerned, and why should a method be elaborated which concentrates on the pelvic floor and disregards the cervix? If the spontaneous dilatation of the cervix is not dangerous, why is the spontaneous dilatation of the vagina and perineum so full of danger? Dr. Polak has given us some beautiful results to study and I think that we should be interested in the immediate results of labor and until they are impossible of improvement, we should not worry about the late results. A low child mortality is the real criterion as to the superiority of one method of delivery over another, provided the maternal mortality is the same in both instances. Another peculiarity in Dr. De Lee's presentation that I cannot understand is, that he elaborates upon the dangers of the caput succedaneum to the child and says that he avoids this with prophylactic forceps. The question is, since he never interferes with the first stage of labor, whether or not a caput succedaneum only forms in the second stage of labor. We know that it does not, since who among us has not seen a caput succedaneum on children born by cesarean section? This argument then will have to be discarded.

DR. HUGO EHRENFEST, ST. LOUIS, MISSOURI.—Dr. Davis has referred to a fact which is important in this discussion. He would like to have the neurologist testify as to the damage done by forceps extraction.

The neurologist indeed is the one who wants the baby extracted quickly because long-continued compression of the head in his belief is disadvantageous to the later physical and mental development of the child. Unfortunately the obstetrician has accepted this opinion, though as a matter of fact it positively is incorrect. It is based solely on statistics collected in institutions for the feebleminded and insane asylums, by asking the mother of such a feebleminded child whether she had a forceps operation, or whether she had a hard labor. Babies, stillborn after forceps delivery, obviously are not counted at all, and by simply taking the mother's word for it, the large number of those who had a hard labor is not surprising. Actual evidence now available proves beyond any doubt that intracranial damage is due rather to quick compression, to quick and excessive molding than to continued compression. This evidence has been supplied by obstetricians who have followed up their own cases and have compared end results with the exact history of the labor ten to fourteen years ago. Such investigations proved beyond any doubt that all procedures which hasten the passage of the child, and which cause quick and excessive molding, such as the use of pituitrin, of forceps or breech extractions, are more likely to be responsible for intracranial injuries manifesting themselves only later in life than merely a long labor.

DR. CARL HENRY DAVIS, MILWAUKEE, WISCONSIN.—As it has a definite relation to this obstetric symposium, I wish to report the results of a recent questionnaire sent to twenty members of this Society.

Last winter a surgical colleague asked me to examine his wife, a para ii, who had been delivered of her first baby by cesarean section because of a central placenta previa. She wished to go through a normal labor. He wished to know if this were safe since she has a normal pelvis. I went over the situation with the husband as regards the probabilities in the case, and gave him the results of my study of the literature. In addition, I sent a questionnaire to twenty members of the Society, stating briefly the facts and outlining a possible plan of management.

In answer to the question, "Do you favor the dictum,—once a cesarean, always a cesarean?" 13 out of 20 answered "No"; 7 out of 20 answered, emphatically "Yes"; 13 out of the 20, with more or less qualifications, favored giving this woman the test of labor, while 7 were opposed to any test of labor. The husband in going over the situation with the family and the two surgeons with whom he is associated finally decided that in view of the wide difference of opinion among experts, cesarean section should be repeated.

On the 16th of May the patient was delivered by the surgeon who performed the first section. It was found that for the most part there was a good scar, but at the upper angle of the old scar there was a very thin area about the size of a quarter. The scar was excised, the uterus again sewed up carefully and it is believed that she can go through a subsequent pregnancy with relative safety. She probably could have gone through this labor spontaneously, but with such a marked thinning of the uterine scar at one end, with a third pregnancy she might have had an early rupture.

Will Dr. Polak tell us whether or not in his private practice the number of operative deliveries are proportionately low? I judge that his statistics are from clinic cases, which, of course, do not correspond to cases specialists see in private practice.

DR. HAROLD C. BAILEY, NEW YORK CITY.—If we are to reduce our infant mortality, we must go back to the autopsy room and follow up the head cases where there is cerebral hemorrhage. In 100 consecutive cases in which the head was opened, nearly 50 per cent were spontaneous deliveries; 9 were forceps deliveries, and 6 were versions or breech extractions. The 50 per cent going on to forceps or breech extractions were operative deliveries for dystocia. Over 50 per cent with cerebral hemorrhage were spontaneous deliveries.

DR. FRED L. ADAIR, MINNEAPOLIS, MINNESOTA.—In following up the causation of hemorrhage in the newborn it has been found associated with delayed coagulation time and delayed bleeding time in most cases; therefore, we will have to record a considerable proportion of these hemorrhages as not purely obstetrical but associated with certain underlying blood conditions which can be readily corrected by appropriate therapy.

DR. RUDOLPH W. HOLMES, CHICAGO (closing on his part).—The one great thing that I tried to picture in my paper was that modern obstetrics has not produced the diminution of maternal and fetal mortalities which was promised; that I felt the recent tendency of considering all pregnant women in a pathologic state, necessitating radical intervention, contributed to our failure. Further the oft repeated statement that "this paper is prepared for the purpose of presenting a new operation for specialists," is far from the mark; any physician has the right under the law and his conscience to attempt it. As a result, too often an unwise recommendation is promiscuously accepted. All the cults of modern obstetrics have their adherents: what one man may accomplish by exceptional skill is more than offset by those who fail in a refined technic and dexterity. The modern general trend in operative obstetrics has not benefited the woman or the unborn child. It is time that what is privately conceded to be the fact should be publicly decried.

I regret that I have stultified Dr. De Lee's intelligence by my statistics, but death is the completion of all things for the individual; the concrete evidence that the percentage mortality in hospital now is directly comparable to a hundred years ago deals with plain facts.

If Dr. Harris does not like my figures he must go to Julius Levy of the Infant Welfare Department of his own state, for he made the investigation concerning the

midwife practice of Newark. I know the fallacy of figures, but if we concede the old statistics quoted were wrong then we must concede the recent figures are wrong; if one is right we have equal justification in accepting the others.

I stand back of what I have written; I am merely opening the trail so that others may pave the way, that we may have conservation of mother and child which is to be attained, not by operative intervention routinely, but by truly scientific investigation into the causes of maternal and fetal deaths, and furnish an adequate preventive measure or measures. If all women having passed through a normal confinement were required to have gynecic operative repair to correct the injuries of labor, then it would be a timely thing to devise routine operative means to consummate delivery without those ravages. But so long as it is merely the incidental woman who demands operative correction of traumatism of birth a routine obstetric operation of some sort or another is a great mistake, and does not correct or mitigate the many evils of labor—on the contrary, unwise intervention increases the risks.

As I see it, the progress of the future in obstetrics is coming from the development of knowledge of antenatal pathology, the correction of diseased states in the fetus by scientific prenatal care and therapy. Who knows but that a refined gestational care may eliminate pelvic deformities in the fetus so that the future woman will be born with normal pelvic structure, and therefore will mature anatomically and obstetrically perfect. Endocrine pathology is of moment in obstetrics today; the future will show that internal secretions have an enormous import in the normal physiologic maturation of the fetus; disturbed, they abound with possibilities in the causation of what kills so many infants, "congenital weakness."

For many months I have asked each and every pregnant woman who came to me how many of her friends prevented conception from fear of labor, and one only had a friend who inhibited the possibility of a family on this ground. Selfishness and economic problems are more important in this connection than any assumed fear.

DR. JOHN O. POLAK, BROOKLYN, NEW YORK (closing).—My paper has brought out the discussion I had hoped for, and apparently all of us are absolutely agreed, but, it seems to me, we are looking at this matter from different angles. We are specialists. Therefore, we can give these women something that the general practitioner cannot give them, and we do it, but we have no right to teach our students in the face of such statistics as have been brought forward resulting from the plan of aseptic expectancy, and interfering only where there are definite indications, that De Lee's method or Potter's method or anybody else's method is the thing to do. We have no facilities in any medical school in this country to teach that sort of obstetrics.

I have the highest regard for Dr. Potter and his work. I have seen his work and am familiar with it. I have learned to do version better by reading what he has written and seeing him do it. He has included in his method everything that is worth while in version, but it is going to do harm and cost numberless babies' lives if we as a Society say this is the plan to teach our students.

I will answer the doctor's question by saying no, my statistics are taken from the cases as they come to us in the clinic where they have had thorough prenatal work. My private operative incidence is very much larger than that reported, for not only are the majority of my cases pathologic, but I am doing what Dr. De Lee and Dr. Potter are doing, I am endeavoring to give every woman the benefit of a relatively painless labor in the hands of a specialist by individualizing the cases.

Brooke Melanchton Anspach (1876-1951)

-M.D. U Pennsylvania 1897
-Professor GYN Jefferson Med Coll 1921
-Author of Textbook of Gynecology