

THE TREND OF MODERN OBSTETRICS: WHAT IS THE DANGER? HOW CAN IT BE CHANGED?

BY BROOKE M. ANSPACH, M.D.
Philadelphia

At the present day, Nature no longer dominates the practice of obstetrics. The modern obstetrician no longer patiently awaits her pleasure, assisting only when it becomes evident that help is necessary. Today, on the slightest provocation and often on decidedly uncertain grounds, he takes matters into his own hands. He is not content even to await the onset of labor but takes steps to induce it at the time when he believes the process should occur. After the cervix has become dilated, or when it is easily dilatable, he turns the child *in utero* and delivers it feet first, or if the head of the child has reached the perineal floor, he completes delivery at once by means of episiotomy and the aid of forceps. If a case promises to be difficult, he ignores the natural channel of expulsion and delivers the child through an abdominal incision.

What excuse does he give for thus interfering with the normal process of labor? He aims to alleviate the agony of labor, to shorten for the expectant mother the tedious hours of suffering and incidentally to end the suspense and uncertainty as to when labor will begin. Such methods have become so prevalent that it has become necessary that we insist upon knowing whether the claims of their advocates are well founded.

Unfortunately, the average laywoman accepts the situation with eagerness. She sees only the promised relief from pain and never considers whether there is increased danger to herself or to her offspring, taking it for granted that such is not the case.

To a certain type of woman, fortunately rare, the fate of the child is a secondary matter so long as she herself is released from suffering. The overwhelming majority of expectant mothers, however, would at once reject any procedure that increased the risk to the infant. How quickly they would appreciate the futility of shortening the second stage of labor did they but know that the most severe pains of labor and those most difficult to control occur during the first stage, when version and forceps are of no avail; and that in the second stage,

with the constant and efficient aid of the accoucheur, anesthetics may be so administered as to almost nullify the distress of labor. Indeed, she may well inquire whether these various practices do more than merely bring on labor at a convenient time and shorten its duration by an operative procedure for which full and complete anesthetization is necessary.

Let us suppose that the laywoman now definitely asks the cost. How do these methods of procedure influence the subsequent condition of the mother and affect the fate of the child? What have the chief exponents of these "labor-saving" plans reported in the way of maternal and fetal mortality?

Reed, who induces labor at the estimated term by means of a tube or a bag in order to prevent oversize and disproportion between the child and the pelvis, reported a maternal mortality of 1 per cent and a fetal mortality of 6 per cent in 200 cases. Watson, who induces labor by administering castor oil and pituitrin, in 195 cases had no maternal mortality, but had a fetal mortality of 6 per cent.

It is not always easy to induce the uterine muscle to expel the fetus before the allotted time. All methods of inducing labor are accompanied with certain dangers from which they cannot be dissociated. No matter how careful the technic or how skillful the obstetrician, infection, separation of the placenta, prolapse of the cord and death of the child from the injection of pituitary substance loom large as grave dangers.

The method of shortening the second stage of labor as a routine procedure by the performance of version is an astonishing proposition, to say the least, especially when no abnormalities are present and Nature gives promise to deliver the patient in due time. For years breech presentations have been regarded as increasing the risk to both child and mother. At first thought it would seem that such a plan as routine version would be rejected as preposterous, and nothing but the skill and dexterity of the inventor of this method, who has been able, by virtue of his unusual gifts, to impress his onlookers, would tend to lead the medical profession to consider seriously so remarkable a plan of treatment. It is not surprising, though, that, even in the hands of the originator of routine version, the fetal mortality should be high.

Potter's first report for the year ending August 31, 1920, gave a fetal mortality of 6.7 per cent. A striking fact in this report is that 12 children who were born alive died with convulsions during the first thirty-six to seventy-two hours. The following year's report, ending August 31, 1921, given in his book (*Version*, Mosby, 1922), is not entirely clear, but he admits for version as an obstetric procedure a fetal mortality of 2.3 per cent. In addition, it may be noted that in

1130 cases he had 4 craniotomies and 100 Cesarean sections. The unkind critic might add that in difficult or abnormal cases, when possible, he had elected to employ the abdominal route.

When we consider the proposition of De Lee we are impressed, from the beginning, with the fact that here there is actually debatable ground and that we must not, even for a moment, compare the prophylactic use of forceps after an episiotomy with either Reed's or Potter's proposals. Indeed, there is some justification in the advocacy of forceps used prophylactically, and yet, after weighing the matter carefully, even here one must decide that interference in a normal case as a routine measure is unwise and that both the mother and the child will do better if Nature is permitted to take its course. De Lee, at present, furnishes no statistics, so far as we know. His last report gave a gross fetal mortality of 3.6 per cent in 9258 cases, but assuredly these cases were not all treated prophylactically with forceps.

As compared to a difficult forceps or version operation, Cesarean section is a simple operative procedure, but we agree with Holmes that it is a grave mistake to believe that Cesarean section is accompanied with less danger than is attendant on what may be termed a tolerably difficult forceps or version delivery. No one will deny that in difficult cases a larger proportion of living babies are secured by this method, but there often follows a certain morbidity that remains with the woman throughout her life.

If a young woman were asked to decide between a Cesarean section and a living child, and a difficult labor with the risk of losing the infant, she would be wise to choose the latter method. A young woman may lose her first baby and yet may later bear numerous other living children. In fact, in the writer's experience, difficult first labors are not uncommon in healthy young women due to rigidity of the soft parts alone, and while the first labor may be prolonged and tedious, and in *exceptional* cases the infants may perish, subsequent pregnancies may terminate normally and easily. Being assured of this fact, how much more complacently would the woman look forward to a natural birth than to a second abdominal operation? There is considerable truth in the epigram, "Once a Cesarean, always a Cesarean."

What about the dangers of interference with the natural processes of labor? Is not the risk to both mother and child increased materially? Holmes, three years ago, declared that in spite of the introduction of aseptic methods the mortality rate in obstetrics had not been lowered, whereas in all other branches of surgery, antiseptics and anesthetics had markedly reduced the mortality. As a reason for this, he pointed to the unjustifiable interference with Nature's process of delivery.

Ehrenfest has called our attention to the fact that in at least 40 per cent of all properly performed autopsies on stillborn infants and

those dying within the first few days after birth, intracranial traumatic lesions of some kind are discovered. Although it is true that such traumatisms have been known to follow spontaneous labor, in by far the larger number of instances severe traumata are observed to follow delivery by artificial means or by the use of instruments. "However," says Ehrenfest, "careful consideration of the various mechanical factors directly responsible for the traumatization of the child would seem to lead to the inevitable deduction that a higher incidence of injuries must be looked for if the teachings of some of our ultramodern obstetricians should prevail. No amount of personal technical skill, unavoidably acquired at the cost of many fetal lives, in my belief, could neutralize the augmented risks to the child of a routine version, followed by immediate extraction, of forceps extractions seriously recommended even on the high head for the sole purpose of shortening the suffering of the parturient woman or made necessary by the elimination of important accessory expulsive force in twilight sleep. No personal effort of the accoucheur could obviate the dangers of a sudden and excessive compression of the fetal head quickly forced through an unyielding birth channel by a large dose of pituitrin."

"Most clearly," this observer declares, "it has become the duty of those who advocate the artificial termination of labor under general anesthesia, in order to overcome the unquestionably slower and more painful process of spontaneous delivery, to prove that such methods do not imply a greater immediate and later risk to the life and health of the infant."

Eden also declares himself against routine interference, and asserts that "one of the first principles in the conduct of labor is non-interference. We are passing now," he says, "through a phase of meddling midwifery which should be viewed with great concern. Operative delivery should not be resorted to unless absolutely necessary."

What, then, may we expect the fetal mortality to be in conservatively conducted labor, and how does it compare with the results of the routine methods employed at present. If we read the report on the midwife by Nicholson, we find that in 51,693 certified deliveries in the city of Philadelphia there was a fetal mortality of $2\frac{1}{2}$ per cent and a maternal mortality of $\frac{1}{8}$ of 1 per cent. From this it might appear that the modern obstetrician is a distinct menace to the community. The truth of the matter, however, is that the obstetrician is able to beat these figures, which look better than they really are, for obvious reasons, when he adheres strictly to asepsis and pursues a rational policy. This is shown by the excellent report of Polak, whose fetal mortality in 1000 consecutive cases was 2.5 per cent, and by the admirable work of Beck, who wrote on the subject, "Is Interference Justifiable after Twenty-four Hours of Labor when no Other Indication

is Present?" In the latter's series there were 138 prolonged labors; spontaneous deliveries were effected in 1125, and the total infant mortality up to two weeks was 3 per cent. We would recommend a careful perusal of Beck's paper by all those who routinely interfere with labor on the plea of lowering mortality and morbidity for both mother and child. Let us draw particular attention to his closing words: "Our only conclusion, therefore, against the routine advocated in this paper is that it calls for considerable courage and is accompanied with considerable worry on the part of the attending obstetrician."

Statistics must, of course, be carefully scrutinized before we accept them at their face value, and in the determination of the fetal mortality as influenced by the methods employed in delivery, we should exclude the fetal deaths that, beyond any reasonable doubt, are due to causes other than the methods employed. Potter, in his book (*Version*, Mosby, 1922), evidently has attempted to do this, for he states definitely that version has a mortality of 2.3 per cent. In arriving at that conclusion it appears that he has excluded all those fetal deaths that may be designed as unavoidable and as entirely independent of the method of delivery employed. As illustrative of this, the same purpose is evident in the statement of Danforth, an advocate of conservative treatment; he reports 500 clinic and private cases, showing a gross infant mortality of 3.6 per cent and a corrected fetal mortality of 1.14 per cent. The importance of making this distinction is shown in a series of 400 consecutive private cases of our own. Every private case from the very beginning of practice down to the present time has been included, the last of the 400 being delivered May 4, 1923. These cases, be it clearly understood, were cared for from the beginning to the end of pregnancy, and were not those seen in consultation after labor had begun; nor those seen for the first time within the last three weeks of pregnancy, none were clinic cases; and none were delivered prematurely, that is, more than three weeks from estimated term. In this series of 400 cases there were 9 fetal deaths—a fetal mortality of 2.25 per cent—and no maternal deaths.

Six of the deaths could not be attributed to the method of delivery—they would have occurred regardless of the technic employed, and should, therefore, be excluded, since they were unavoidable. The reader is requested to review them critically:

CASE I.—Small, undersized twin—other one living and well; no difficulty in delivery; born alive but died of inanition within twelve hours.

CASE II.—Child was dead before labor started; placental apoplexy; eclampsia; accidental hemorrhage; vaginal pack; pains began within an hour; spontaneous delivery in four hours.

CASE III.—Child died just before or early in labor; mother missed movement; no heart sounds, although heard plainly the day before; labor was normal and lasted fourteen hours; membranes ruptured after head was on the perineum and the amniotic sac was distending the vulvar outlet; child normal in appearance; autopsy and Wassermann negative. Only explanation was accidental compression of the cord.

CASE IV.—Child died within twenty-four hours of birth; congenital heart disease (autopsy); normal labor.

CASE V.—Child died within twenty-four hours; hydrocephalus and infant idiotic in appearance; normal labor.

CASE VI.—Child died on fifth day from pneumonia; multipara; normal spontaneous labor, six hours. Autopsy and Wassermann negative, except for pneumonia.

In the judgment of the reader, should not these cases be classed as unavoidable deaths independent of any method of delivery?

There were 3 deaths that we may consider as avoidable and directly concerned with the method of delivery:

CASE I.—Central placenta previa; young woman; first baby; version; this was done deliberately to save the mother, but a Cesarean section would probably have saved both mother and child.

CASE II.—Death within twenty-four hours of labor; multipara, forty-two years old; high forceps; occipitoposterior position; cervix not completely dilated but dilatable; interference here was premature; further delay or the use of a Voorhees bag or version might have avoided this fatality.

CASE III.—Death from pneumonia on eighth day; an occiput posterior position in a thirty-year-old primipara; the child was resuscitated with difficulty; the same criticism as in Case II might be made of the conduct of this case.

If the methods of delivery alone are considered, in all there were 3 deaths in 394 cases, or a fetal mortality of 0.76 of 1 per cent. There were 215 primiparæ and 185 multiparæ. There were 36 high and mid-forceps; 44 low forceps; 1 version for placenta previa; 3 induced labors for toxemia; 4 pairs of twins; 16 breech presentations. Cesarean section was done in 10 for the following indications:

CASE I.—Distortion of the uterus following ventrofixation; no progress after eight hours of labor.

CASE II.—Increasing blood-pressure and præclamptic toxemia ten days before term; short, stocky primipara.

CASE III.—Funnel pelvis; history of previous difficult labor, and dead child.

CASE IV.—Cicatricial contraction of vagina and cervix; history of previous difficult delivery, and dead child.

CASE V.—Small pelvis (internal conjugate, 8); large child, 10 pounds 5 ounces; no progress after test of labor; cervix edematous.

CASE VI.—Previous Cesarean section, and multiple myomectomy incisions in fundus early in married life, before conception (Porro operation).

CASE VII.—Multipara, aged forty-one years; dystocia from rigid cervix following cervical repair; no progress after twelve hours and use of Voorhees bag.

CASE VIII.—Pregnancy in right horn of a uterus bicornis; malpresentation and history of two stillbirths.

CASE IX.—Pregnancy in the left horn of the uterus bicornis of the same patient two years later (Porro operation).

CASE X.—Preëclamptic toxemia, placenta previa and transverse position of infant.

We are aware that this is a small series of cases and attach value to the lessons it teaches only because it includes every case, and, so far as we can see, gives an adequate estimate of unavoidable and avoidable fetal mortality in private practice.

Moreover, it has afforded us ample opportunity to observe the value of patient waiting in the practice of obstetrics. Harrar has aptly expressed it: "Patience in obstetrics is next to asepsis, but it must be the active patience of close observation; not the passive patience of ignorance, allowing the mother to become totally exhausted or the baby in imminent period of death before determining a line of action."

Perhaps the most trying cases are the dry labors, with ineffective pains and very slow dilatation of the cervix. Here the Voorhees bag has been of the greatest help, for by its use alone delivery has often been effected.

In the entire series careful antenatal treatment was maintained throughout pregnancy, and we are firmly convinced that in this way the size of the child can be considerably influenced. During labor the expectant plan was adopted and interference was never undertaken unless danger threatened the mother or the child.

The point we wish to make is that practised in this way, obstetrics is a difficult proposition and that some babies are likely to be lost because the obstetrician is unfit at the time he is called upon to act. The most frequent error of commission is to attempt delivery before the os is completely dilated, and to this cause we attribute 2 fetal

deaths in our series. Not infrequently the importunities of the family and of the patient prevail, and although the obstetrical attendant may be successful in spite of this handicap, in the long run he will do better if he uses a bag or waits until the cervix is fully dilated.

Granting that conservative obstetrics give the best results, we should endeavor to surround the patient and the attending obstetrician with the most ideal conditions, so that *whenever labor begins* the patient will have adequate and skilled attention throughout, *no matter how long it lasts*. But to practise obstetrics in this way—patiently to wait, taking no thought of one's convenience, forcing one's self to the limit of endurance—is so laborious a task that it seems almost impossible for a man to continue it indefinitely. How often the obstetrician has struggled wearily through the night, only to be confronted in the morning by some grave obstetrical problem that he had to meet promptly and effectually if he was not to lose both patients. Dare we hesitate to ask whether many of the methods for the conduct of obstetrics that have arisen in later years have, wittingly or unwittingly, been originated primarily for the benefit of the harassed obstetrician, and thus, secondarily, of course, for the benefit of the patient? Furthermore, has not the drudgery of this work kept many physicians and nurses from practising obstetrics or induced them to abandon it just when they have had enough experience to render them really valuable?

At a meeting of this Society two years ago, we suggested, as a remedy, the formation of obstetrical partnerships in maternity hospitals. There seemed to be considerable doubt as to whether such a plan would be feasible. There is a conviction in the minds of many that the pregnant woman pins her faith to one man and would be disinclined to employ as accoucheurs a partnership of two or three, any one of whom she might happen to get as her immediate attendant. The objection has been raised that a case started with one man could not be turned over to another without resulting disadvantage to the patient. Personally, we believe that the disadvantages are more fancied than real, and that the woman would soon realize what it meant to her and would give her enthusiastic support. If such a plan did come to pass, fetal and maternal mortality and morbidity statistics would improve, and the pernicious practices now in vogue would disappear, since they would no longer be attractive.

In closing this paper, we wish to pay tribute to Potter and to De Lee for their contributions to the art of obstetrics. Potter has certainly demonstrated how version and breech extraction should be done, and we have no doubt that in many posterior positions of the occiput his plan will take the place of axis-traction forceps and of Scanzoni's maneuver and give better results. His work marks a distinct and valuable advance in the development of the technic of

version. It is to be deplored, however, that he does version routinely. On two occasions we have seen De Lee perform his prophylactic forceps operation; it was a masterly exhibition, and we wish to compliment him on his achievement. When the head is delayed in the second stage, and immediate delivery is indicated, the method of De Lee cannot be surpassed. The obvious criticism of these methods of starting or terminating labor artificially is that we have not yet shown that in this way we can improve on the normal process.

CONCLUSIONS. 1. Routine induction, routine version and routine prophylactic forceps increase the danger of childbirth to both mother and child.

2. There is an unavoidable fetal mortality in labor of between 1.5 to 2 per cent—in other words, that proportion of infants *at term* will be born dead, irrespective of the methods employed. In reporting a series, the details of every fetal death should be given. The fetal mortality in conservative obstetrics at present may be estimated at about 1 per cent.

3. The woman in labor should have constant and continuous attendance of a competent obstetrician throughout labor, no matter *when* it starts or *how long* it lasts.

4. Labor should not be started or ended routinely. Induction forceps and version should not be employed unless they are definitely indicated in the individual case for the sake of either the mother or the child.

5. The practice of obstetrics should be carried on by obstetrical partnerships. When this practice comes into vogue, objectionable routine methods will be abandoned and maternal and fetal mortality statistics will improve.

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DISCUSSION

DR. GEORGE W. DOBBIN, Baltimore, Md.—I want to thank the Society for this opportunity to discuss the paper just read by Dr. Anspach. It is a subject in which I am intensely interested, and for the past several years have conducted my practice along lines similar to those laid down by Dr. Anspach. I have nothing to say in criticism of the paper, because I am entirely in accord with everything he has said.

I feel that the aggressive methods of urgent obstetrics that have come up in the last few years have been developed, as he says, more for the benefit of the accoucheur than for the woman herself, and I cannot but feel quite strongly that the promise of relief from the pains of labor is used by the advocates of these procedures to increase the material gains of their practice. Version can be an extremely difficult operation, and no obstetrician can do many without realizing that under the best conditions a certain number of children will inevitably be lost. I have never had the privilege of seeing Dr. Potter operate, and am told by those who have that his skill is very great. However, I feel very strongly that it is very dangerous advice to give to those who have less experience.

The conclusion of Dr. Anspach's paper has particularly interested me, because it is this part of the work that I have done more or less of myself.

In 1915 I found that a rapidly increasing obstetric practice, which had to be kept up because it was necessary for me to make my living, was getting too much for me. I could not get away from my work at all, I could get no holiday or vacation, and two patients falling in labor at the same time was a very serious calamity. I thought the matter over very carefully and am free to say that the development of more aggressive obstetrics did not suggest itself to me as a means of solving the problem. What I did, however, is just what Dr. Anspach has suggested, in forming a partnership with a well-trained obstetrician. That was in 1915, and up to the present the alliance has been highly successful.

What Dr. Anspach suggests concerning the difficulty of having a patient satisfied when getting the services of an obstetrician she did not directly engage, is much more fanciful than real when one is dealing with a partnership. We have little or no difficulty in educating our patients to this effect; in fact, many of our patients realize we are working together and ask that both of us be present at the time of delivery.

Whenever possible the physician to whom the patient has originally applied conducts the delivery; but in the care during pregnancy, which

frequently covers six or seven months, every effort is made to explain to her the workings of our partnership, so when she actually falls in labor we have rarely experienced any difficulty whatsoever.

I have no hesitancy in stating that our efficiency has very materially increased as the result of the partnership. Two trained men working together can handle any case far better than one working alone, and in the event of complications the advice and moral support of a co-worker is most comforting.

Dr. Anspach's results are certainly remarkably good. Before leaving Baltimore, I looked up our records and find that his are somewhat better than ours. He presents an actual fetal mortality, I think, of 0.76 per cent. Our mortality is larger than that. In the last three years we have delivered 817 women with a total loss of 48 children; total mortality, about 9 per cent. This, however, includes all macerated babies and death that can in no way be attributed to the obstetric management of the case. When these are eliminated we have only 10 deaths, a corrected fetal mortality of 1.22. I must also note that I have been a little more liberal in calculating this obstetric fetal mortality, as I have considered one case where death was due to compression of the umbilical cord, a condition which I think Dr. Anspach eliminated in his statistics.

As I remarked at the outset, I am particularly interested in this subject and desire to congratulate Dr. Anspach for the able manner in which he has presented it.

DR. WILLIAM C. DANFORTH, Evanston, Ill.—In order to indicate what results may be attained by intelligent application of conservative methods, I have brought with me a brief résumé of 1029 cases, comprising the work of our maternity for the years 1921 and 1922. Of these 447 were primiparæ and 582 multiparæ. Of these 886 were various cephalic presentations, 665 of them being L. O. A. There were 48 breech, the remainder being various less common presentations. In this series there was a forceps incidence of 19.2 per cent. There were 23 Cesarean sections, 41 breech extractions, including 22 versions. Our maternal mortality in this series was 0.39 per cent. In this series the total number of infants delivered was 1046. Of these 49 died and at some time prior to the discharge of the mother, usually on the twelfth day. The total mortality, including all cases up to the time of discharge, was 4.6 per cent. Excluding premature babies, and including all deaths occurring in labor and subsequent to delivery, gives a mortality of 3.5 per cent.

In the first three months' work in this same maternity 144 cases were delivered—61 primiparæ and 83 multiparæ. In this series we find a forceps incidence of 25.2 per cent. With 1 Cesarean section and 9 breech extractions, including 2 versions, there was no maternal mortality.

To compare with the 400 private cases which Dr. Anspach has given in his paper, I have data upon a series of my own of 400 consecutive cases—160 were primiparæ and 240 multiparæ. Of these 265 delivered spontaneously. There were 109 forceps deliveries, of which 85 were low forceps; 13 breech extractions, including version; and 13 Cesarean sections. Exclud-

ing premature babies, this series gives a fetal mortality of 1.75 per cent. Including all premature babies for the entire series and all deaths up to the time of the mother's discharge, the total mortality was 3.5 per cent.

Among the fetal deaths of babies at or near term we find that 3 died of *ablatio placentæ*, 1 of asphyxia from cord compression, 2 of anemia (these children having been delivered in cases of *placenta previa*), and 1 which died after a difficult high forceps.

When one considers the figures which Dr. Anspach has just given us of the results in a series of cases conservatively managed, and if one in addition considers the figures contained in the report of Dr. Polak of about a year ago and those which I have given in a former report of 500 consecutive cases, it seems to me that the burden of proof rests upon the shoulders of those who advocate routine operative interference. These reports all show too clearly the value of intelligent conservatism. It is not a debatable question that the application of forceps in many cases is a beneficent thing, and any man of experience knows that the lives of some infants are saved by interference. It seems, however, that the best results are still to be expected from a watchful conservatism supplemented by the proper carrying out of operative interference upon clear indication.

DR. HUGO EHRENFEST, St. Louis, Mo.—All I wish to say in discussing this paper is that no discussion of what modern operative obstetrics does to the child should be limited to the mortality of the fetus. In my monograph, to which Dr. Anspach alluded, I tried to make the point that we must include into our consideration all injuries; also those not fatal. Many of them may be only temporary in their effect, others permanently invaliding the child physically and mentally. I am of the opinion that there are various conditions still being considered as congenital defects which, as a matter of fact, are results of birth injuries.

We should certainly not consider the dangers of obstetric procedures to the child solely from the standpoint of fetal mortality.

DR. HAROLD C. BAILEY, New York City.—May I ask a question? Why should these stillbirth figures be revised? Is it proper for us to be excused from delivering premature infants and macerated fetuses? Does not the entire subject of toxemia come in under that heading? I think it is a great mistake to have a presentation of mortality statistics along the line the author has taken. Mortality statistics of premature dead fetuses, stillbirths and neonatal deaths, I believe, should take all such deaths from the seventh month of pregnancy on to thirty days' postpartum.

DR. CARL HENRY DAVIS, Milwaukee, Wis.—May I add a word to Dr. Bailey's remarks as to the character of the statistics? They need correction and standardization. We should take in everything from seven months on, count it all in, and then may consider the operative deliveries separately.

I, too, have checked up on a series of 405 deliveries for a paper which Dr. Danforth and I are preparing together. Taking all cases from seven

months I had a total fetal mortality of 3.9 per cent. There were only three deaths which could in any way be attributed to the delivery. Two of those were cases of occipitoposterior position in primiparae with flat pelves, with premature rupture of the membranes, the fetal heart going bad when the cervix was not completely dilated. In each case it was completed manually and the woman delivered finally by version and extraction with the dead baby. One woman had the old-fashioned easy labor pains two minutes apart, where I let fifteen minutes go by without listening to the fetal heart, and there was a concealed prolapsed cord, with easy delivery, but a dead baby. We should individualize every case. Having interns or nurses hold back the head when we are trying to reach the hospital is bad practice. One should listen to the fetal heart after every contraction during the perineal stage and deliver quickly when the change in the fetal heart indicates danger.

DR. ANSPACH (closing).—As the hour is late I will only say that if you do not exclude premature births you cannot show the difference between conservative methods and routine operative methods of delivery of women in labor at term. If you do not exclude the fetal deaths that are entirely independent of the methods employed there can be no accurate comparison.

In reply to Dr. Danforth, I did not refer to Dr. Potter as the inventor of version but as the originator of routine version.

I wish to thank the gentlemen who took part in the discussion.