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## Original Communications

### THE RESPONSIBILITY OF THE OBSTETRIC TEACHER IN RELATION TO MATERNAL MORTALITY AND MORBIDITY\*

BY B. P. WATSON, M.D. (EDIN.), F.R.C.S. (EDIN.), F.A.C.S.  
NEW YORK, N. Y.

*(Professor of Obstetrics and Gynecology, Columbia University, Director, Sloane  
Hospital for Women)*

IN RECENT years and especially since the termination of the World War there has been in all countries an increasing interest in and anxiety regarding maternal mortality and morbidity. All sorts of inquiries and commissions have been set up and reports published with so far, little apparent result. I say apparent result because statistics are traditionally unreliable and in the case of the maternal death rate more so than usual. When we try to compare the maternal death rate today with what it was fifty years ago we are attempting the impossible for the figures of fifty years ago, when registration was very defective in all such countries as had it, are not true figures.

For example, registration of deaths in its present form was begun in Scotland in 1855 and it is startling to find that the maternal death rate from all causes was apparently higher in the years 1915-1922 than in the years 1855-1864, whilst the death rate from puerperal sepsis was the same in the two periods. (Table I.)

It is inconceivable that the death rate from puerperal sepsis is as high today as it was in 1855. At that time the teaching of Semmelweis had not been generally accepted. White's teaching has been largely forgotten.

Epidemics of childbed fever were still frequent in hospitals and of course Listerism was not yet born. There must be a fallacy some-

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NOTE: The Editor accepts no responsibility for the views and statements of authors as published in their "Original Communications."

TABLE I. DEATHS FROM PUERPERAL CAUSES IN SCOTLAND, 1855-1922—DECENNIAL MEANS

YEARS	TOTAL DEATHS	METRIA OR PUERPERAL FEVER	OTHER DISEASES AND ACCIDENTS OF CHILDBIRTH	TOTAL	PUERPERAL FEVER	OTHER DISEASES OF CHILDBIRTH
1855—1864	512	180	332	4.9	1.7	3.2
1865—1874	595	213	382	5.1	1.8	3.3
1875—1884	660	252	408	5.2	2.0	3.2
1885—1894	658	306	353	5.3	2.5	2.8
1895—1904	605	246	359	4.6	1.9	2.7
1905—1914	703	216	488	5.6	1.7	3.9
1915—1922	704	194	510	6.2	1.7	4.5

TABLE II. RECORDS OF DR. C. E. DOUGLAS AND HIS PREDECESSOR IN PRACTICE

DATE	NUMBER OF CASES	DEATHS FROM SEPSIS	RATE PER 1,000
1847-1864	936	16	17.0
1880-1891	550	4	7.2
1891-1923	1670	2	1.7

where and this is borne out by a most interesting communication by Dr. C. E. Douglas who has in his possession the full midwifery records of his predecessor in a mixed town and country practice in Scotland. In his case book there is a record of 936 cases attended between 1847 and 1864. (Table II.) There were twenty maternal deaths, giving a rate of 21 per thousand. In the ten years ending 1864 the general maternal death rate for the whole of Scotland, according to the Registrar's returns, was 4.9 per thousand. In 14 of the 20 who died no mention is made of any complication or operative interference at delivery, so it may be assumed that they died of sepsis—a mortality rate from sepsis of 17 per thousand. As Douglas points out, such a rate is not surprising when we realize the nature of the obstetric procedures of these times. A tedious first stage was treated by venesection in the first instance, followed by "an opiate enema"; if this did not suffice the os was dilated manually. The second stage was mainly concerned with support of the perineum, for hours if need be. Hamilton mentions having done this for twelve hours without leaving the patient—and "fine lard," to the extent of a pound for a case, was used to lubricate the passage. The third stage was a still more extraordinary performance. You felt along the cord till you could reach the center of the placenta, and if this could be done it was ready for extraction. Twisting the cord around the fingers of the right hand you pulled on it till it came away, again supporting the perineum with the left hand. If the placenta were retained for more than an hour it should be removed. If adherent, the placenta is to be grasped by the examining hand, and "pressure is now to be made upon its substance, bringing its circumference towards its center and detach-

ing leisurely and carefully all that can be separated by this manipulation. The separated mass is to be extracted by pulling with the navel string."

In the same district, Douglas himself has practiced and from 1880 to 1923 attended 2,200 midwifery cases. From 1880 to 1891, the time during which it was beginning to be realized how important antiseptic precautions were, he had 550 cases with a septic mortality of 7.2 per 1000. From 1891 to 1923 he had 1670 cases with a septic mortality of 1.7 per 1000. (Table II.) Those figures are, probably, far more reliable than those of the Registrar-General, although the numbers dealt with are small, and they go to show that there has been a very considerable reduction in the death rate from sepsis and other causes in the last seventy years.

We cannot, however, get away from our present day figures of maternal mortality and they are very much the same in all countries in which registration of deaths is on a comparable basis. I quote the Scottish figures as being more immediately familiar to me but they differ little from those of the United States and it is not my intention to draw comparisons. It may be said generally that the maternal mortality from all causes in all countries varies from 4 to 7 per thousand and that it has shown little change in the past twenty years. Dr. Janet Campbell writing of England says, "The general death rate has been reduced one-third; the infant mortality rate has been halved since the beginning of the century, yet the maternal mortality rate is little lower than it was twenty years ago." (*Maternal Mortality, Ministry of Health Publication, London, 1926.*)

While it is certain, therefore, that the maternal death rate has been reduced in the last fifty years it has not shown that rapid diminution observed in the general death rate in recent years. Is this because we have reached the irreducible minimum or are some of these deaths preventable? It is held by some, and there are certain biologic facts to support them, that the pregnant and parturient woman has "an increased susceptibility to death" (Douglas) as compared with her nulliparous sister and that the process of reproduction must in certain instances result in the death of the mother. Those of us who are engaged in hospital and consulting obstetric work realize, however, that maternal deaths, in many instances, are not the direct result of the parturient process as nature planned it but are the result of ill advised, ill timed or misdirected efforts to supplement or supplant nature's methods.

We have heard a great deal in recent years about obstetrics being a surgical specialty and that the obstetrician should be first and foremost a surgeon. That is all to the good in so far as this conception has been the big factor in improving the technic of the delivery room

but it is all to the bad if it leads the budding practitioner to think that every case must be subjected to surgical procedures. Therefore, along with this insistence on the surgical nature of obstetrics there must go a redoubled effort on the part of teachers to impress upon their students the essential normality of the vast majority of cases and the dangers of unnecessary interference.

There is a greater need today than ever there was to preach against "meddlesome midwifery" because with our increased hospital facilities, the attendance of trained nurses, and the ease with which a "set up" for the operation can be made there is a greater temptation to interfere. Do our students in their hospital training see too many instrumental deliveries in proportion to normal deliveries? Speaking from my own experience I think that they do and that they are likely to go away with a wrong impression unless the teacher is at pains to discuss fully with them the indications for every interference. They see the skilled obstetrician emerge successfully from a difficult forceps case, or version and breech delivery and do not always realize that his success is due partly to the ideal conditions under which he is working as regards "set up" and assistance, partly to his individual skill, and that if they attempted the same procedure in the home of one of their future patients they would be lacking in both. They do realize this in the case of a major surgical operation and from this point of view it must be driven into them that operative obstetrics is surgery and very often major surgery and that before they can undertake these operations they must have more training than they can possibly receive in their undergraduate course.

Such a statement at once raises the question as to how much we can teach the student before graduation and, in the absence of any future special hospital training, how much obstetric work such teaching equips him for. This question has been answered more fully in the case of medicine and surgery than it has been in obstetrics. An undergraduate course in surgery does not pretend to train the student as a surgeon. It aims at training him in diagnosis, in being able to recognize the necessity for surgical interference, and in the performance of minor surgical operations. Our aim as obstetric teachers should be the same.

How best to accomplish that aim is in some details a matter of opinion. I, personally, am convinced that a course of theoretic instruction should precede clinical study and that that instruction should be largely in the form of lectures and demonstrations, supplemented by the reading of a standard textbook. Trained as I was in the Edinburgh School where the systematic lecture constituted and still constitutes such an important part of the student's training I may be regarded as prejudiced, but experience of other methods in other schools has confirmed me in my belief that it is only by such means

that the average student can be grounded in the principles of the subject and be given that broad outlook which is essential to the clinical application of these. The lectures should reflect the individuality of the lecturer. They should deal with broad facts of anatomy and physiology and should be freely illustrated by clinical word pictures. They should be dogmatic,—the student will learn to argue about them later. They should all be given, I think, by the same man and he should be the senior member, or one of the senior members, of the department. After such a broad survey of the whole subject, and this can be easily accomplished in forty or fifty lectures, the student is in a position to benefit from his individual clinical instruction and contact with patients in a way which would be otherwise impossible.

In most medical schools the time set apart in the curriculum for clinical obstetrics is too short. An absolute essential is that the work should be concentrated and that over a certain period it should be the only activity of the student. A period of actual residence in the hospital or in a hostel in connection with it is necessary if he is to get the full benefit.

In planning the student's course of clinical instruction emphasis should be laid on diagnosis and this can be learned only in the prenatal clinic and prenatal wards. In all our teaching hospitals we now have large prenatal clinics which afford ample material for instruction. This should consist in a thorough training in clinical pelvimetry and abdominal palpation. It is most gratifying to find how quickly the student acquires proficiency in these if he is given the proper instruction and guidance at the beginning. It requires patience and time on the part of the teacher but these are amply repaid when he finds that after a short time his student can fairly accurately measure and type a pelvis, diagnose presentation and position and form an estimate of the relative size of head to pelvic brim. If we could insure that every graduate left his medical school with such a training, that he appreciated the importance of such examinations in every case and realized that a disproportion called for further examination and consultation before the onset of labor we could confidently look for a marked diminution in the maternal death rate within the next few years. It is well within our capacity to give such training and well within the capacity of the student of today to fully avail himself of it. In this one direction alone there are, therefore, great possibilities.

In the prenatal clinic also he must be taught the importance of the various complications of pregnancy especially the early and late toxemias, the anemias, the heart affections, the focal infections. He should see carried out, and should carry out himself, a full physical examination of the patients, take their blood pressures, examine their urines. When abnormalities are detected he listens to the advice given them. He follows them into the prenatal wards when their condition

calls for hospitalization. He is soon struck by the number requiring such hospital care. The late Dr. Studdiford found that over a period of seven years, 20 per cent of the patients attending the prenatal clinic at the Sloane Hospital required special advice and treatment and that 12 per cent were admitted to the prenatal wards. The student is thus impressed with the importance of prenatal care and sees the rapid improvement in the patients as the result of appropriate treatment begun early. It is brought home to him that eclampsia is a preventable disease and to have it occur in a patient for whom he is responsible is a reflection on himself.

He will not get all this from his work unless he is guided and taught. There must be an atmosphere of enthusiasm at every clinic. It is all very prosaic to us but it is all new to him. He is keen to learn, keen to recognize the various conditions he has heard and read of, and elated when he does so. To my mind there is no stronger argument for a systematic theoretic training before the beginning of clinical work than this joy of being able to recognize in the patient before him some condition about which he already knows. Knowledge so acquired is never likely to be forgotten, even when with passing years enthusiasms wane.

With such teaching and practice in the prenatal department the student is in a position to study and conduct labor. He has passed through his hands patients who have been labelled as normal and for whom a normal unaided labor is anticipated. He has given them a good prognosis. If he has not done so himself he finds from the history sheet that some one else has. When he sees these patients in the labor room he knows that, given time, the great majority will deliver themselves unaided. His part is to maintain an attitude of watchful waiting. The training he has got in abdominal palpation enables him to diagnose with certainty presentation and position without vaginal examination. He must be taught to follow the progress of the labor from the frequency and strength of the pains and the behavior of the patient during them. The descent of the head during the second stage is followed by abdominal palpation. It is impressed on him that every vaginal examination is a possible danger to the patient. He keeps careful watch on the fetal heart. He is in close touch with the patient throughout the whole duration of the labor.

His surgical training ought to have drilled him in aseptic technic. My experience is that he is often sadly deficient in this. I hope our surgical colleagues are duly grateful to us for directing and completing this part of the student's education. That technic should be as simple as efficiency will permit. In his early years of practice the young graduate will probably have to do his work under less favorable conditions than in his school hospital and he should be able to appreciate and insist on the essentials. When operative delivery is

necessary the definite indications for it ought to be explained and discussed. In undergraduate teaching such procedures as "prophylactic forceps" and routine version have no place. He must be given practice in the various obstetric manipulations and operations but the proper place for that is in the manikin room.

A not inconsiderable part of the total maternal mortality is from the antepartum hemorrhages. What should we teach our students regarding the treatment of these? The only safe teaching to my mind is to impress on them more and more the seriousness of every such case and the absolute necessity for consultation and hospital care as soon as the condition shows itself. The cases which end fatally are usually those which have been temporized with in their own homes and admitted to hospital only after repeated hemorrhages and attempts at treatment such as packing. Those which survive the immediate hemorrhage help to swell the septic death rate.

And when sepsis does supervene under those or under any other circumstances what ought we to teach them regarding it? In the first place we must try to visualize for them the actual processes going on in the body. We must picture to them a large, rather flabby, very vascular and edematous organ undergoing more or less rhythmic contractions which produce periodic changes in the state of fulness or emptiness of the large venous sinuses and lymphatic channels. As it contracts blood and lymph are being squeezed out of these channels into the general blood and lymph stream. As it relaxes material from the interior of the uterus may be sucked into them, and so, at the next contraction, be passed on to the general circulation. The inner surface is a large raw or granulating area with tags of varying size of dead and dying tissue attached to it. In these are numerous organisms of various kinds, for the most part harmless saprophytes but also pathogenic or potentially pathogenic germs. In the fight against these we picture the barrier zone of leucocytes in the layer just under the surface, and we imagine the attack of the hosts of bacteria being repelled by them. We hope that the defenders will win the day, and that, with the death of the last invader, victory will be won. We dread the giving way of this first line of defence and do everything to preserve it, and would not wilfully remove it. Its giving way is indicated to us by the prolongation of the fever, by the more rapid pulse, by the more toxic condition of our patient, by the noninvolution of the uterus. We are almost certain a breach has been made in it when a rigor occurs, and we are sure when we find the organisms in the blood. But the fight is not yet over. We now imagine the deeper parts of the uterine wall invaded but defences being rushed up—the leucocytes and tissue cells are reacting and proliferating, the serum has developed in it antibodies which, like poison gas, stupify the organisms and render them easy victims for the leucocytes or kill

them outright. Those that invade the blood stream do not long survive and recovery may take place. Or we see the attack directed along the lymph channels. The temperature is high but fairly steady, there is pain, there is tenderness above the brim of the pelvis, there is induration to be felt—a cellulitis has developed. Cellulitis means strong reaction on the part of the tissue cells, and we rejoice for the localization. But it must be watched. Resistance may still be insufficient and suppuration may occur, which must be detected early to prevent wide extension. Or again resisted in the actual tissues we imagine the organisms working their way insidiously along the venous channels, producing thrombosis as they go, and escaping from time to time in large numbers into the blood stream or carried into it on small emboli. This is the picture when, after days of high fever, our patient has recurrent rigors with hyperpyrexia and positive blood culture, a septic thrombophlebitis. Her state is now more than serious, but there is still a slender hope of recovery.

Or we see the defence fail altogether and the leucocytes and tissue cells killed off in great numbers. Minute beads of pus everywhere form in the thrombosed vessels and in the lymphatic channels, the tissue cells are felled by the toxins, they have made their utmost effort, and are incapable of more. The organisms march on, invading every part of the body through blood and lymph stream, settling down to renewed effort in those parts that please them—the serous surfaces, the lungs, the heart. The woman is doomed.

All of which leads up to an emphasis of the danger of interference with the interior of the uterus in cases of sepsis, postpartum or post-abortal.

With such training as a student can the doctor live up to his ideals in practice? Let us grant at once that it is difficult for him to do so. In the first place he is handicapped in his prenatal work by the failure of his patients to consult him early in pregnancy. With the education of the public the importance of antenatal supervision is being brought home to women and in the future less and less difficulty will be experienced in this direction. The medical profession in the United States deserves great credit for the enlightening of the public in this regard. Ballantyne of Edinburgh was one of the first to impress upon us the importance of antenatal care but Scotland and England have lagged behind this country in the provisions made for carrying it out. They are now very much alive to the necessity and there will be a rapid improvement in the immediate future. The big problem there, as here, is in the rural areas.

Where hospital accommodation is obtainable it is easier for the practitioner to live up to his ideals in the conduct of labor than when he has to practice domestic obstetrics. In the latter the importunity of relatives and the saving of his own time tempt him to interfere when

his better judgment would restrain him. In the hospital his patient is watched by competent internes or nurses while he proceeds with the rest of his day's work and he is called only when necessary. Are something approaching the same conditions obtainable in domestic practice?

As you know, in Britain, a large percentage,—50 per cent or more of the women are delivered by trained midwives. The maternal mortality among the cases so cared for is certainly not higher, and in many areas is lower, than in those delivered by doctors. The drawback to the midwife is that she is not capable of giving adequate antenatal supervision. There is, therefore, a growing feeling among obstetric teachers in Britain that in large industrial areas and in rural districts there ought to be active cooperation between doctor and midwife, that while the former should be responsible for the antenatal care of the patient the latter should, in normal cases, be in attendance at the delivery, calling in the doctor only should necessity for interference arise. I know several very busy practitioners in working-class communities who have organized their obstetric work along these lines. One of them, who has the assistance of two or three trained and registered midwives, informed me recently that he had reduced the incidence of forceps delivery in his practice from 30 per cent to 3 per cent and that he now has leisure for reading and attending society meetings which he never had formerly. I mention these facts for your information and not with any idea that conditions here would necessarily permit of such an arrangement in our industrial and rural areas. There are many aspects of the midwife problem in Britain which are disturbing and call for investigation and improvement. One is that the best type of fully trained nurse does not take up this work because of the uncertain and often poor financial return and because of the poor social status she has. With such a system of cooperation with the doctor I think that a better type of woman would go in for the profession and quickly take her proper place in the community. If some such thing came about I feel certain that it would go a long way to solve the problem so far as Britain is concerned.

I do not yet know enough of conditions here to venture any opinion as to how such a system would work in the United States. The word midwife conveys a different meaning here from what it does in Britain and European countries. The "Trained Obstetric Nurse" would be a better designation. Is it possible that,—I know the subject has been discussed by many and I ask the question for my own information,—the active cooperation of the "Trained Obstetric Nurse" and the doctor may be a possible way in which to overcome the difficulty of the large domiciliary obstetric practice? Such a nurse would act the part the interne does in hospital practice. She would require to be trained in the conduct of labor as well as in obstetric nursing. Those of us who

have been accustomed to working in hospitals with such well-trained nurses know how efficient they become, how accurate their diagnosis and prognosis and how reliable they are in every way. Until sufficient hospital accommodation is provided to take care of every delivery, and it will be a long time till that comes about throughout the country, it seems to me that this method may have possibilities. It would give the busy practitioner conditions approaching those enjoyed by the hospital obstetrician and would enable him to maintain the standard of obstetrics at a higher general level than has hitherto been possible.

1125 FIFTH AVENUE.

*(For discussion, see page 396.)*

## OBSTETRICAL SOCIETY OF PHILADELPHIA

STATED MEETING, DECEMBER 2, 1926

DR. B. P. WATSON, of New York, by invitation, presented an address entitled **The Responsibility of the Obstetrical Teacher in Relation to Maternal Mortality and Morbidity.** (See page 277.)

## DISCUSSION

DR. RICHARD C. NORRIS said that it seemed in this country, in recent years, that better results are obtained by increasing more and more our hospital maternity work. We are urging more and more women to go to hospitals for their confinement for the benefit of the woman herself as well as the practitioner of obstetrics. The trouble with the system of cooperative or teamwork of a specially trained nurse and a doctor, in remote districts, is that the work, practically, would largely fall to the associated trained obstetric nurse. I am not sure that our Public Health Service, which is demanding more and more the services of the trained nurse as a substitute for the rapidly decreasing country doctor, is not making the public service nurse a higher type of midwife. The midwife problem we have tried to get rid of but find, practically, we cannot do it. If the country doctor cannot be a trained obstetrician, which seems to be a fact, this work must fall into the hands of women properly trained for it, whether you call her a trained obstetric attendant or a higher order of midwife. It is impossible to have the doctor in the outlying districts in attendance on two or more women actively in labor at remote distances from each other. The more practical plan is to increase everywhere community maternity hospitals, even in outlying districts. To educate a group of graduate nurses as obstetric attendants, and attempt to have them cooperate with country doctors, would ultimately lead to the nurse replacing the doctor, if they exhibited, as they probably would, the self assurance and attitude of the modern trained nurse. He should prefer the slogan of "more obstetric hospitals" rather than "more trained nurses to do the doctor's work."

DR. L. S. COGILL wondered what effect—in the near future—periodic health examinations are going to have upon these statistics.

If we do follow-up work during the entire so-called childbearing period of the woman instead of merely during the prenatal stage, we can check up much earlier any existing pathology, which otherwise would result in ill health or death of mother or infant.

If the infant is followed through health clinics from birth to motherhood, much needless pathology will be avoided.

This plan properly carried out, plus good care at birth should tend toward reduction of the present maternal and infant morbidity and mortality.

DR. P. BROOKE BLAND said that Dr. Watson's paper has placed the stamp of approval on the teaching of obstetrics in Philadelphia institutions and the plan he has outlined is being followed today. The mind of the medical student, the prospective general practitioner of medicine, who must of necessity be 33 per cent obstetrician, must be inculcated with the well-known truth that the successful practice of obstetrics resides, first, in zealous prenatal supervision, so aptly described or named by Holland, "The Strategy of Obstetrics," and, second, in pursuing during labor an aseptic watchful waiting plan, as mentioned by Dr. Watson. Hasty manual or indiscriminate instrumental and abdominal delivery have combined to contribute to the unusual or the exceptionally high mortality and morbidity in this country. To all familiar with the present situation it is quite obvious that something is woefully wrong in our obstetric work and it is equally obvious that something must be done, some plan inaugurated, to reduce or eliminate the present day high morbidity and mortality.

DR. GEORGE M. BOYD was impressed with the conservative viewpoint taken throughout this address and was fully in accord with his counsel as to the wisdom of testing the stages of labor, keeping in mind the fact that the primipara may go 24 hours and the multipara 12 hours without developing dystocia. In 1921 he reviewed 10,642 consecutive cases delivered in the Philadelphia Lying-In Charity. This report was prompted by the feeling that many obstetricians exercised too great haste in labor and too often resorted to surgical interference. The report was made to determine the frequency of spontaneous delivery and also the maternal and fetal mortality. It was found that if the time element was observed, in 90 per cent of the cases the labor was spontaneous and that surgical interference was reduced to the minimum. By following this course there was a fetal mortality of 5.39 per cent. A study of 10,000 cases in 1915 made by the Sloane Hospital for Women, New York, the Columbia Hospital, Washington and Johns Hopkins Hospital, Baltimore, showed about the same fetal mortality.

DR. WILLIAM R. NICHOLSON felt that it would be not an unmixed evil if men were sent out from the various medical schools of the country without any knowledge of the so-called "high application of the forceps." The indication for this operation is very rare, and most of the cases subjected to it either should have been cesareanized or should have waited for a longer test of labor.

It is impossible to teach the differential diagnosis between these two classes of cases to a man in his undergraduate course, and it is also impossible to teach these to a short term interne.

He thoroughly agreed also that too little time is given to the teaching of obstetrics in the medical schools today and was convinced that much of the time spent on the benches or assisting at gynecologic and obstetric operations, is pure, sheer waste, and that if the time now devoted to this useless activity were devoted to the actual study of prenatal cases, together with the use of the mid-pelvic and low forceps, that the student would benefit, to say nothing of the added safety to his patients.

With regard to the question of the midwives, there is, of course, in this country, not the least danger that the better class of patients will ever be in the hands

of the midwife, and no nation, as yet, has ever been able to get away from the midwife, and the trend on the Continent and in England, has been to improve the knowledge of the midwife, in order that she may care for her patients with less danger.

It is not the time nor place to quote midwife statistics, but the Pennsylvania mortality and morbidity percentage compared very favorably with those furnished by a similar collection of cases delivered outside hospitals.

The plan of inspecting each case after delivery is the only feasible plan to insure good care and the expense incurring in this plan is very much less to the state than it would be if these women were all hospitalized.

DR. WATSON (in closing) said that in Edinburgh the clinical material in hospitals was being used almost entirely for the midwife to the exclusion of the medical student, and one of the first addresses he gave in Edinburgh was a protest against the midwife. In the four years he was there, he changed his opinion because he found that the properly trained midwife was filling a place in the community. In the large working communities in Britain where men earn a bare living wage, where both doctor and nurse cannot be paid, where there is not sufficient hospital accommodation to provide for every confinement, the midwife does good work. She would do still better work if she always cooperated with the doctor. Dr. Watson was very much struck with the enthusiasm of certain busy practitioners in mining areas and manufacturing towns who had employed in their practice trained midwives. The doctor exercised prenatal supervision; the midwife did the actual delivery, only calling in the doctor when necessary. The number of instrumental deliveries was greatly reduced and the doctor himself had more leisure. Dr. Watson quite agreed with Dr. Norris that to have sufficient hospitals to accommodate every woman in labor would be the ideal solution of the problem. That is going to take some time and we must be feeling out in all directions to meet the present situation. In regard to teaching students, we must get back to essentials, we must teach clinically. Students must know biochemistry and metabolism and the various laboratory tests, but don't let us have them depend on these things to the exclusion of simple clinical tests. I believe that we must go back more and more to the old method of making them listen, inspect, palpate, auscultate, and make up their minds about the whole clinical picture, using laboratory methods to fill in the blanks and complete the diagnosis.