

Special Articles

SOME IMPRESSIONS OF A GYNÆCOLOGIST IN POST-WAR EUROPE*

BY SIR BECKWITH WHITEHOUSE, M.S.(LOND.),
CH.M.(B'HAM.), F.R.C.S.(ENG.), F.C.O.G.,
F.A.C.S.(HON.)

*Professor of Midwifery and Diseases of Women,
University of Birmingham, England*

To speak to the medical profession of the Dominion of Canada is an honour of which I am deeply sensible. May I thank you, therefore, in most sincere terms for the invitation to address this general session of our Association.

The science and art of medicine have their own special problems, only to be solved by work and observation in the laboratory, operating theatre, or at the bed-side. The means to this end and the application of the practical results which accrue differ widely, however, as the result of environmental or economic factors, and a study of local variations and progress is always of interest to the onlooker.

In this Dominion you have your own difficulties inherent to the vast areas in which you practise. Accustomed as we are in the Old Country to limited distances, we, at home, cannot conceive, for instance, how medical, surgical or obstetric aid can be brought to the log-cabin or small township over here when skilled help is most urgently needed.

In England, Scotland and Ireland, medical problems are not essentially of a geographical nature, owing to the development of the cottage hospital and the utilization of the large teaching hospitals as bases for difficult and complicated cases. With us, perhaps the most important discussion today is the relation between so-called voluntary hospitals and the municipal or state institutions, a problem now almost peculiar to Great Britain and to which I shall refer again later. On the continent of Europe other post-war difficulties have had to be faced by the medical profession, as the result of both political and economic influences, which have left their stamp not only upon technique but also upon personnel. In recent years it has been interesting to visit various clinics in Europe, and today I propose as a gynæcologist to tell you something of my impressions of these centres, and of the men whom it has been my privilege to meet.

In 1922 I had the opportunity of going to Brussels and seeing the work of the late Professor Dépage at the Hôpital St. Pierre. Dépage was the senior general surgeon in Belgium during the War, and was responsible for the medical organization of the Belgian army. The hospital where I saw him working was a large institution, rather of the type associated by us with the name "infirmiry", but not so well furnished and equipped as similar state institutions in England. The main operating theatre was a large room where two operations were performed simultaneously. Each operating team was literally roped off, and visitors, of whom there appeared to be many, strolled about outside the operating "pens". Whilst Dépage performed a gastro-enterostomy, his first assistant at an adjoining table removed a tuberculous appendix. I remember that Dépage was very annoyed because this assistant did not transplant the ovaries in his patient for our edification. The indication for transplantation of the ovaries I failed to understand, and I mention the incident to illustrate what I have noted in other continental clinics, *viz.*, the exaltation of the science and art of surgery in some of these institutions to the detriment of the best interests of the patient. In our commonwealth I think we may say that the patient's welfare *always* comes first, and that science is a servant and not a master. Long may it remain so!

Another point that impressed me in Brussels, was the age of the assistants. Not only the first but also the second and third assistants in the Dépage Clinic were all very senior men, not only willing but proud to work for one whom they regarded as a great master. The remuneration of these men was small, a few hundreds a year. Most of them were also attached to hospitals in outlying areas, at Louvain, for instance; but their duties at the great Central Clinic appeared to be so onerous and exacting as to preclude much work elsewhere of a private or lucrative nature. The general impression I gained of Belgian surgery was that the technique is good, but that there is, or rather was, a tendency to strain after the spectacular.

The private hospitals and clinics were very good, but the public institutions did not attain to the comfort and equipment which we are accustomed to associate with our leading hospitals. My visit to Belgium was soon after the War, and the remains of the German occupation were still very much in evidence. During the years that have since passed, it is, therefore,

* Read before the Canadian Medical Association, at Ottawa, June 23, 1937.

probable that the hospitals of Brussels have undergone radical changes.

In 1930 I paid a visit to Denmark and Sweden with the Gynæcological Visiting Society of Great Britain. Our destination was primarily Professor Gammeltoft's Clinic at Copenhagen, Professor Essen Möller's Clinic at Lund, and the Radium-Hemmet at Stockholm. Let me tell you, in the first place, something about Gammeltoft. Some of you may have met him. If so, you will know the gifts with which he was endowed, his delightful and charming personality which made a brief acquaintance appear at once like a life-long friendship, his excessive keenness, his technical skill, his art as a teacher, and also that nervous energy which placed him so much above his fellows, but which terminated his medical career in such a sad and tragic manner. Gammeltoft lived in a house next door to his hospital, and took a very active part in the practical training of his students in obstetrics. He regarded his duties very seriously, and was on constant duty day and night. His was a whole-time Chair, with a remuneration of about £1,000 a year, and his house. One could not fail but be impressed with the difference in the *practical* obstetric training of Danish medical students and those in the British schools, where the teachers are part-time, and have other interests. In recent years the training of medical students in Great Britain in the science and art of obstetrics has undergone very considerable revision. A longer period in the curriculum is now devoted to the subject, and each student has to spend a period of one to three months actually in residence in a maternity hospital before he is allowed to work on the "extern" districts. I still believe, however, that the teaching of our students in this very important part of their training will not be complete until the *senior* teachers themselves reside in the maternity hospitals and actually teach *practical* obstetrics. So often with us, indeed I think I may say almost universally, does it happen that the practical teaching and demonstration of midwifery upon the living subject is in the hands of junior men or women actually themselves learning their art.

The conscientious training of students in midwifery is an exhausting ordeal, as in the nature of things it cannot be regulated by the clock. It follows, therefore, that the physical and mental strain should not be too long endured. Neglect of this important consideration can only lead to nervous wreckage with the results shown in the case of the brilliant holder of the Copenhagen Chair.

Denmark, like Sweden, is not a large country, but the population is scattered. It is sometimes difficult, therefore, to obtain medical assistance immediately during obstetric emergencies. To meet this, the midwives are trained, and are

expected to perform, when necessary, such operations as version, low forceps, manual removal of the placenta, and the repair of minor perineal tears. Needless to say, the training of Danish midwives is very thorough. It is in the hands of a professor who has no other responsibilities. The Midwives' Training School is entirely separate from that of the medical students, and the appointment and remuneration of the whole-time professor and his assistants are responsibilities of the Danish Government.

The new Midwives' Act may eventually lead to the adoption of separate clinics for midwives and medical students in England. I sometimes wonder whether this is a good thing; but perhaps I am tinctured with the views of my old teacher—Dr. John Fairbairn. He was, and I presume still is, a strong believer in teaching the medical student and the pupil midwife in the same class. They will work together afterwards, and so why not let them start together, was his dictum.

After leaving Copenhagen my next destination was the old university town of Lund in Sweden, where the Gynæcological Clinic was presided over by Professor Essen Möller. Essen Möller, then approaching the time of his retirement, was still in the very first rank of the exponents of abdomino-pelvic surgery, and I shall ever regard it as one of my great privileges to have had the opportunity of seeing this artist at work in his own clinic. I have witnessed many operations in many clinics, but never have I been so impressed as I was on that June morning in Lund. Essen Möller's reputation as one of the greatest of European surgeons was amply upheld by the beauty of the technique that he displayed before us. He performed three operations, two hysterectomies and an ovariectomy. The Professor and his assistants sat whilst opening and closing the abdomen, a point which typified the unhurried orderliness of the whole procedure. Essen Möller worked with a simplicity, gentleness, and sureness that made an immediate appeal to everyone present, and during the whole of the operations there was complete silence. It was interesting to note that his anæsthetist was a nurse. Also that whenever he spoke English was the language he employed; and everybody in that theatre understood it as well! Commenting upon this fact later, Essen Möller told me that as far as they were able he and his staff always endeavoured to respect the language of their visitors—a delicate compliment which unfortunately is not possible for all of us to return. The Professor was ably supported by Dr. Wachenfeld, who now occupies a professorial Chair himself. Wachenfeld was a first-class assistant, and when I remember him, I think of the abdominal retractor which was hooked to a belt surrounding his ample waist.

The contractions of his abdominal muscles served as a very good substitute for a third hand!

After operating, Essen Möller showed us over a part of the hospital, a simple, airy, and spotlessly clean institution, with plenty of room and with flowers everywhere. An adjunct that appealed to me were the large public rooms for convalescent patients. These resembled comfortable lounges which one is accustomed to associate with a luxurious hotel. No British hospital that I know is provided with public rooms where the convalescents can gather; but perhaps we do not keep our patients in hospital long enough to require such accommodation!

From Lund I proceeded to Stockholm, one object being to ascertain if possible, the factors associated with the low maternal morbidity which place Sweden and Holland in a very enviable position in Europe. The state lying-in hospital in this northern Venice is called the "Allmänna Barnbordshust"—popularly abbreviated to the "A.B.B."—not the "B.B.A."!

In Stockholm 94 per cent of all confinements take place in hospital, and throughout the whole of Sweden, the number of maternity patients admitted to hospital is increasing. There is little domiciliary midwifery, and for the same reason very little "private" midwifery. It is practically a state problem from beginning to end. The state-trained midwives are distributed on a geographical basis, and air transport is provided by the Government for midwives who officiate in the far north, *e.g.*, Lapland. I was interested, a few years later, to hear from Professor Marshall Allen in Melbourne, that he has instituted a very thorough aeroplane obstetric service to overcome the geographical difficulties associated with the practise of midwifery in the Australian bush.

No complicated obstetric problem is ever dealt with in Sweden outside the walls of a hospital, and, therefore, the work of the midwives is practically confined to diagnosis and conduct of the normal case. It is interesting to note that occipito-posterior presentations are regarded as being normal, unless, and until, impaction occurs from non-rotation of the fetal head. Incidentally, I noted that the forceps rate in the clinic of Professor Bovin, the head of the Municipal Lying-in Hospital, was 3.7 per cent, and only three Cæsarean sections had been performed in a consecutive series of 2,434 cases. Contracted pelvis is practically unknown in Sweden, and this fact, associated with careful institutional treatment conducted by a staff of midwives and doctors specially trained for the service over a long period no doubt determine the low mortality rate.

An interesting point regarding statistics, ascertained by Professors James Young and Miles Phillips, is that in some medical centres of Europe the material upon which figures are based is not identical with that of other centres with which comparison is made. For example, in Holland, deaths from toxæmia and eclampsia are regarded as medical and not obstetrical items, and, therefore, are omitted from statistics which provide the figures of maternal mortality!

It is rather a long step from the northern capitals to Central Europe, but I think, perhaps, you may be interested in a visit that I paid to Vienna and Budapest in the spring of 1935. Both Austria and Hungary have passed through a very difficult time, both politically and economically, since the War, and at the period of which I speak, both these centres were only just commencing to feel their feet once more. In the political instability which existed, the science of medicine had suffered. There was talk of Chairs being discontinued, and departments being closed down. Medical practitioners of all grades had felt the financial pinch, and expenses, both departmental and personal, had to be ruthlessly cut. There is good reason to believe now, however, that the corner has been turned and, in the absence of further upheavals, that the great medical centre of Vienna may once more rise to eminence, and reoccupy the position in Europe from which it has been deposed by the force of circumstances.

It is interesting to study the result of the adverse factors which I have mentioned upon the medical work of Vienna. In the first place, there is no doubt that during recent years many of the holders of professional Chairs and Lectureships have felt a sense of insecurity in the tenure of their offices. The same political influences which have led to the departure of Aschheim and other great scientists from Germany, have been feared in Austria. It is to be hoped that these fears are groundless, for the reorganization of clinics which might be associated with a new régime, accompanied by the uprooting of teachers whose heart and soul are not only in their departments but in Vienna itself would be a disaster of great magnitude. Amongst gynæcologists today the names of Oskar Frankl, Adler, Schiller, Wernher, Kahr and Halban mean so much that one cannot imagine the Vienna School bereft of the personality of these teachers and artists.

Vienna has long been the home of vaginal hysterectomy, and since the War the popularity of the vaginal, as opposed to the abdominal route of approach, has, if anything, increased. Professor Adler told me that one reason for the preference of the Viennese gynæcological surgeon for the vaginal route, was the fact that

the operation required very little in the way of suture materials, and that the patient was soon out of hospital. Adler's patients get out of bed on the fourth day and the majority go home on the tenth. It is, therefore, a very economical operation—an important point these days—quite apart from other more obvious advantages. Whilst in Vienna, I had the opportunity of seeing this operation performed by various surgeons and for various indications, and there is no doubt that the Viennese School are masters of vaginal technique. Professor Adler in his clinic performed a radical operation for carcinoma of the cervix uteri per vaginam under local anæsthesia. Access was obtained by means of a para-vaginal or Suchardt's incision, and the uterus was removed with a large amount of para-cervical tissue. No attempt was made, however, to remove the lymphatic glands, these being dealt with by means of radium in a container placed against each lateral pelvic wall at the end of the operation. The local analgesia, absence of bleeding, and excellent condition of the patient at the end of the operation were very impressive, as also was the wonderful team-work on the part of all concerned in the theatre.

In most clinics I visited there appeared to be a superabundance of assistants, able to provide just the right kind of assistance at the right time. That an army of such trained assistants is, however, not an essential, was ably demonstrated in the case of vaginal hysterectomies performed by Professor Kahr and Professor Wernher. I do not think that I am exaggerating when I say that both these surgeons are past-masters in the art of vaginal hysterectomy. Kahr works in the old Allgemeines Krankenhaus, forever associated with the name of Semmelweis, and, for historical reasons, still practically the same as when the Semmelweis trod its floors. I saw Kahr perform two vaginal hysterectomies. The operations were carried out without difficulty or hurry, and with a clear demonstration of all the steps. In less than half an hour both patients were anæsthetized, operated upon, and returned to the ward! Professor Wernher is an equally skilful exponent of the operation, and his dexterity is outstanding.

What did not impress me in Vienna were the methods adopted in two well known clinics for the surgical treatment of uterine and vaginal prolapse. This is rather surprising when one reflects that the basis of our modern vaginal methods for dealing with prolapse originated in Vienna. Both radical colpoplasty and uterovaginal interposition are Viennese operations, which in their time were valuable contributions to the therapeutics of prolapse.

Pathology, I am glad to say, still lives up to its very high tradition in Vienna, and I know

of no better place where gynæcological pathology can be studied. Oskar Frankl's work is, of course, well known, and I am glad that he is once again restored to surroundings where his work and teaching can be carried on in accordance with those principles which are so dear to his heart. Nothing, I think, demonstrates the true artist in Frankl better than the beautiful models which he uses in his teaching, all designed by him, and made by his own hands. Another remarkable personality amongst the gynæcological pathologists is Walter Schiller. It is probable that some of you have met him, as the last letter I received from him was from New York. If so, you will know something about his enthusiasm and gift of stimulating a like enthusiasm in his audience. One late afternoon in Vienna, he discoursed to us upon his researches into ovarian pathology for three hours, and then took us off to the opera, where we interspersed the acts of "Die Fledermaus" with snacks of dinner. Yes, Walter Schiller is a remarkable man. Not only is he a pathologist, a musician, and an entomologist, but he reads ancient Greek for recreation in the moments he can snatch from his scientific researches!

I am not qualified to discourse upon personalities who figure prominently in Vienna in other branches of medicine and surgery. They are there, and will fully maintain the old tradition of Vienna, if, as I have said before, medicine can be left outside the political arena, and its exponents allowed to continue their researches and teaching in peace for the good of science and humanity.

Vienna is within a few hours of Budapest, but the latter is entirely a different city, with contrasts at every turn. When I visited it in 1935 it appeared, certainly on the surface, to have weathered the storm better than Vienna, and to be making material progress towards recovery. The influence of politics was, however, still evident in the large floral map in the centre of the city, with the detached portions of the country clearly shown. This map is planted each year by the women of the city. The same influence is shown in the prayer for the restoration of Hungary, recited by all students at the university in each faculty before the first morning lecture of the day.

Budapest has an excellent medical school, with modern buildings and a good post-graduate organization. Here, as in Vienna, most gynæcological operations appear to be performed under local analgesia. I saw Professor Frigeysi, the chief of Gynæcological Clinic No. 1, perform a sub-total hysterectomy, an interposition operation for prolapse, and a curettage, all under local analgesia, and this appeared to be entirely satisfactory. Post-graduate students act as assistants in the professorial unit, and I was

impressed with the very moderate charges made for maintenance.

Research into tissue extracts and hormones occupies a prominent place in the university laboratories at Budapest, and useful work is being done there. I was interested in a method in process of elaboration, of providing temporary sterility, possibly stimulated by the proximity of Moscow!

In the time that is left I should like to say something about Holland in connection with the development of its maternity services. Holland is, of course, a small country, and this, associated with the fact that all parts are easily accessible, has led to an extremely satisfactory organization. A factor in the low maternal morbidity is undoubtedly to be found in the mentality of the women themselves. The Dutch woman is not obsessed with the element of fear which, in recent years, has dominated the women of many western countries, largely the result of being repeatedly told on platform and in newspaper that child-bearing is a risky luxury, and that she will be lucky if she gets away with it! Further, Dutch women will not have chloroform, or any other anæsthetic or analgesic for their confinement if they can avoid it. They regard it as a grave reflection upon their pluck, and if it should be necessary, I am told that they are particularly careful to say nothing about the incident when they return home to their villages! Then again, the development of the organization known as the Dutch "Green Cross" is doing excellent work in areas remote from the cities. The head of this voluntary organization is Dr. Bergemann, and it provides infant welfare, pre-natal and post-natal care in nearly every village in Holland. The local midwife resides in a small comfortable house, especially built for the purpose, which not only provides accommodation for her, but also includes an out-patient department where her patients are seen and examined. Here also, public health, social hygiene, and home nursing are taught. Medical supervision is provided from the nearest city.

The midwife in Holland is a very important member of the community, and not only her training but also her subsequent duties are carefully supervised by the State. There are no "free-lance" midwives; they all belong to a national service. Admission to this service is by examination which is competitive, since only a certain number of vacancies created by death, resignation, or age, are available each year. The training of the Dutch midwife is very thorough and occupies three years. In the first instance she must pass an examination to show her proficiency in subjects of general education, including a language other than her own. An accepted pupil is taught during her first year such subjects as anatomy, physiology, chemistry and physics, attending daily lectures on all these subjects.

Subsequently she receives a very thorough training in midwifery, both theoretical and practical. Finally, she is dispatched as a *locum* to one of the practising midwives in Holland, whilst the latter returns to her training school for a compulsory post-graduate course every three years. This very excellent arrangement not only provides opportunities for the young midwife to assume sole responsibility, but prevents older women from becoming "stale", and too soaked in routine. The training school for midwives that I personally visited is in Rotterdam. It was under the charge of Dr. Wesselink, and is well worth a visit by those interested in the development of maternity services.

Holland has, however, places of medical interest other than obstetric. Particularly would I draw your attention to the Physiology Clinic of Professor Noyons at Utrecht, and the new Laboratory of Pathological Anatomy of Professor de Vries at Amsterdam. The latter is a very fine building, modern in design, and equipped with every possible gadget for teaching and research in pathology. The post-mortem room, with its spotlessly clean amethyst-coloured tables, each fitted with a large scialytic light, is probably the most luxurious apartment of its kind in Europe. To study pathology in Amsterdam is not only to study a science but indeed an art.

And now to return home, my home; what are the general impressions I gained after these various journeys? In the first place, I think I may honestly say that my faith in the British general practitioner as an integral part of medical practice was never higher than it is to-day. On the continent of Europe the general practitioner, as we know him, does not exist. There are any number of specialists and quasi-specialists, young and old, some doing good work, others doing bad; some making a success of life; others undoubtedly living from hand to mouth. But there are few, if any, of those highly respected members of our profession such as we associate in Britain with the best type of family practice. I refer to the doctor who is valued not only for his medical skill but also for his sound advice as a man of experience and a man of the world conversant with every aspect of human life. There is a danger that the British family practitioner may in the future have no place in the medical work of the community. With the multiplicity of clinics established by the State, and the development of what are termed "contributory schemes", the family practitioner of the future may find himself with nothing to do, and be compelled to accept a salaried State office! Fevers, tuberculosis, venereal diseases, diseases of children, ante-natal maternal care, and even contraception, are already largely State-controlled. Specialist hospital services in association with contributory

schemes will soon complete the work, and the British public may one day wake up to discover that they have been "nationalized" in matters medical, and that the family practitioner is no more. Perhaps they will then appreciate what they have lost!

The depletion of work of the family practitioner has naturally led him to adopt other activities, and already we find the development of what may be termed a "sub-specialist" group. Men and women, whilst engaging in general practice, also act as local consultants in various specialist subdivisions of medicine. There is, without doubt, a place for work of this type, especially in country towns and centres of population which cannot support the "pukka" consultant. At the same time there is a real danger, especially in surgery, of general practitioners taking on responsibilities for which neither their training nor their experience fits them. This is a problem which will have to be faced by us in the future, for the lay public is astonishingly well informed these days in medical matters. Although they support and apparently even like the unqualified medical practitioner, they expect only the best from us and are ruthless when their faith in us is displaced.

In midwifery, our British College of Obstetrics and Gynaecology, is endeavouring, by means of its Diploma in Obstetrics, and by its membership, to provide for the public of the British Commonwealth a service staffed by men and women who have proved their fitness to accept the responsibilities of the work which they profess. We hope and expect that in the course of time, the Diplomates will act in their area as local consultants in obstetric difficulties. Similarly, the Members and Fellows of the College will be universally recognized as specialists in the science and art, both of obstetrics and gynaecology, capable of dealing efficiently with any difficulties which may arise.

Another matter on which I hold very decided views is the importance of maintaining in Great Britain our great voluntary hospitals. They are almost as much an institution with us as Parliament itself. There is something about a voluntary hospital which is absent from the municipal or state institution. What it is is difficult to put into words. Perhaps it is best expressed by saying that a person admitted to a voluntary hospital, is a "patient", rather than, or in addition to, being "a case".

I cannot imagine in one of our British voluntary hospitals such things happening as transplantation of the ovaries purely as a surgical "side-show", the removal of a uterus through an abnormally long abdominal incision so that surgeons at the back of the auditorium might obtain a good view of the technique, or the addition of maternal urine to babies' milk to prove the assumption that the addition of

sex hormone is beneficial to the weight curve! All these things I personally have seen in various clinics whilst making mental notes at state hospitals on the continent of Europe. So long as the family practitioner survives and is supported by the great voluntary hospitals with their healthy staff rivalry and competition such incidents are not likely to occur in Britain.

A fixed salary with us is regarded as a dead-end, and this is the reason why young medical men leave the municipal hospitals and apply for vacant appointments in the voluntary institutions where the rewards of success are commonly regarded as unlimited. Even if this is not true, I think that the average British medical temperament prefers the stimulus of a potential gamble on his own resources rather than the safety of a State salaried post!

Many other problems there are that are exercising European minds today, but I must not exhaust your patience. The increasing ravages of cancer in Europe, especially in women; the steadily falling birth-rate; the menace of abortion, illegal and otherwise, both in its influence upon the health of the people, their moral standards, and the population; the increase of contraception since the War amongst all classes, but particularly amongst the educated and leisured classes, are all matters that are troubling us at the present time. Perhaps, in this great Dominion, with its untold possibilities, you are free from such sordid matters as some of those which I have mentioned. I hope so, sincerely. I like to think of you in Canada developing on lines of moral, physical, and mental progress, free from those false principles which in all civilizations have appeared when unhealthy factors arise in the crowded community.

Hospital Service Department Notes

The Intern Who is Dissatisfied

BY HARVEY AGNEW, M.D., F.A.C.H.A.

*Secretary, Department of Hospital Service,
Canadian Medical Association, Toronto*

Internship services have never been so well organized in Canada as at the present time; interns have never been given such an opportunity to gain experience, to profit by staff interest and cooperation, to have good housing, good food, and recreational facilities, yet definite dissatisfaction and unrest does appear here and there. In some hospitals interns are demanding more practical work, particularly in

All communications intended for the Department of Hospital Service of the Canadian Medical Association should be addressed to Dr. Harvey Agnew, 184 College Street, Toronto.