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THE FADS AND FANCIES OF OBSTETRICS. A COMMENT ON THE PSEUDOSCIENTIFIC TREND OF MODERN OBSTETRICS*

BY RUDOLPH W. HOLMES, M.D., F.A.C.S., CHICAGO, ILL.

IT IS useful, now and then, to look backward, for an occasion may arise when necessity will demand that we shall retrace our steps, or at least that we may measure our progress. Without retrospect we may lose the proportion of things and awake to the fact that we have made no advance, in fact have merely run around a vicious circle. We all know how phenomenal have been the advances in obstetrics in many particulars; untold benefits have come from the introduction of anesthesia and asepsis which have made possible many operative procedures which were the dream of the obstetricians of the past. Under the new regime the indications, at first, were clearly and definitely drawn; as the certitude of the freedom from pain from anesthesia and the proximate eradication of sepsis were realized, indications were placed on a broader basis, until they became so loosely laid down that they had no real justification beyond what the operator determined for himself. It is not far from the fact that obstetrics, today, is in identically the position that oöphorectomy held some twenty-five years ago. The indiscriminate employment of operative intervention in obstetrics has accomplished little in the way of conservation of life of the mother and child; in fact, as I see it, conservation of life is not to be realized

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by operation beyond the exactness in determining its justification, and its correct use. If figures may be interpreted to mean anything I believe my data prove conclusively that our endeavors during these later years have been misspent: true conservation is to come from intelligent, scientific investigation of the pathology which underlies and is responsible for so much of our disease in the pregnant and the unborn child. A ruthless operative course in all parturient women is not the solution, for many of the troubles which come to women and the baby are directly incident to the hazards of birth and these are augmented by unwise interference.

We all know how wonderful has been the diminution of the mortality rates for women and infants in private practice: however, the safeguards placed about the mother have accomplished more than they have for her offspring. How many of you know that the death rate for women, in hospitals, is as great today as it was a hundred years ago—the decrease being so negligible that one hardly would know it? How many know that in hospitals the fetal death rate is essentially what it was one century ago? These startling findings are the excuse for presenting this paper. It is my purpose to attempt an analysis of the conditions, to give a tentative explanation and to open the trail so that others may pave the way, so that obstetrics may be a scientific specialty, not a makeshift as it is now.

Is it not seemly that we should take cognizance of conditions obtaining, when this country of ours is fourteenth in the list of civilized countries having statistics dealing with the mortality of the new mother? Is it not seemly that we should consider this matter when 8453 women died, according to mortality statistics, in 1910? To be sure cancer kills 9,857 women, but cancer takes its toll at 58.4 years on the average, while child-bearing takes the young woman in the fullness of life at the age of 29.8 years. Does it imply that neither the public nor medical profession has fully appreciated the benefits of prophylactic medicine? Or is it that scientific pursuit has not yet solved the problem, and we are still groping in the dark!

The masters of the century ending with the beginning of the antiseptic era had developed the art of obstetrics (in contradistinction to the surgery of obstetrics) to a high degree: the skill with which they were able to deliver women in the presence of all sorts and conditions of complications developed a nicety of technic which left little or nothing for the modern authority to improve: in fact very little has been contributed these forty years on the art of obstetrics. The old masters, in spite of the restrictions imposed by the risks of infection, and therefore, lacking an opportunity of developing a technic from practice, were able to conceive the essential principles of the mutilat-

TABLE IV
TREATMENT OF PLACENTA PREVIA
MORTALITIES COMPARED

OBSTETRIC TREATMENT TABULATED BY HOLMES	MOTHERS			CHILDREN		
	NO.	DIED	%	NO.	DIED	%
Ramsbotham*	82	?	?	82	50	60.9
Collins*	11	2	18.1	11	5	45.4
Hardy and M'Clintock*	8	3	37.5	8	3	37.5
Sinclair and Johnson*	24	6	25.	24	13	54.1
Arneth*	9	1	11.1	9	6	66.6
Braun, C.†	37	9	24.3	37	18	48.6
Klein*	11	2	22.2	12	12	100.0
	100	23	23.	183	107	58.4
Read, Wm.: Placenta Previa, 1861, 12 tables.	978	206	21.2	850	447	50.8
††Blacker: all since 1880	22	1	4.5	22	8	36.3
Kouwer	8	3	37.5	8	3	37.5
Ribbius	98	7	7.1	98	39	40.8
Stratz	57	1	1.7	57	36	63.
Fry	14	0	0	14	5	35.7
Galabin	92	15	16.1	92	69	75.
Hautel	123	12	9.7	123	92	74.1
Hirst	28	0	0	28	24	50
Siebert	24	10	16.8	24	8	33.3
Dorman	84	10	11.9	84	38	45.
Welti-Pinard	149	4	2.6	149	34	32.7
Lomer	236	21	8.9	178	105	60
Drejer	49	2	4.09	50	12	23.5
Platzer	46	4	8.7	46	25	53.2
Zedler	16	2	12.5	16	6	37.5
Higgins	75	8	10.6	?	?	
Rotunda Hospital	74	3	4.	?	?	
Murphy	61	2	3.2	?	?	
Klein	138	13	9.4	?	?	
Schauta	234	16	6.8	234	127	54.
Strassmann	231	22	9.5	231	144	61.2
Driessen	125	19	15.2	125	80	64.
Doranth	216	20	9.3	216	152	70.3
Fournier	7	0	0	7	3	43.
Koblanck	467	18	3.8	?	?	
DeLee	30	1	3.3	31	13	41.9
Amadi et Ferri	100	5	5.	100	32	32.
Behm	52	0	0	52	30	60.
Totals.	2756	213	7.4	1985	1075	54.1
Jewett: Am. Jour. Obst.	2010	221	10.9	2020	1159	57.3
Behm, omitted, repeated	40	0		40	31	
	4726	434	9.2	3965	2201	55.5
<i>Abdominal Cesareans.</i>						
††Cases collected by Holmes: also 7 babies died within 14 days.	25	5	20.	25	9	36.
Jewett: Am. J. Obs., p. 943, June, 1909.	95	11	11.5	97	37	34.
Davis, Asa, Am. J. Obs., p. 120, Jan. 1915.	21	2	9.5	21	7	33.3
Davis, E. P., Penn. M. J., p. 292, Jan., 1915.	18	0	0	18	7	37.7
Foulkrod: Am. J. Obs., p. 459, Mar. 1913.	4	1	25.	4	1	25.
Doederlein: Cent. f. Gyn. p. 1383, No. 38, 1913.	146	12	8.9	146	44	30.1
Total Cesareans	309	31	10.	311	111	35.6
Obstetric Treat.	4726	434	9.2	3965	2201	55.5
Preantiseptic Period.	1078	229	21.2	1033	554	53.6

*Murphy: Midwifery, 1862, p. 698, et seq.

†Braun, C.: Gynecology, 1881, p. 561.

††Blacker et seq. to Behm taken from table in "Cesarean Section an Improper Procedure," Jour. Am. Med. Assn., May 20, 1905.

ing operations on the mother—which now more euphonesely are denominated obstetric surgery.

The fact that modern maternity hospitals, where is centered the obstetric skill and knowledge of our profession, have been unable to decrease the dangers of birth to mother and child over the figures obtaining the early part of the nineteenth century is *prima facie* evidence that modern obstetric surgery is ineffectual in combating those dangers. Table I has been prepared to demonstrate this contention. The fluctuations in the maternal death rates, before 1880, ranged from 0.44 to 1.28 per cent, and are only variants which would come to any institution from year to year. Since 1910 the rate varied from 0.41 to 1.01 per cent in different institutions. An analysis of the children was not so graphic in view of the fact that some writers, as Moran, combined abortions and stillbirths, others included stillbirths and those dying in the hospital. Still, the figures show how little progress has been made these many years. There are many arguments which might be advanced to show why present hospital statistics are not comparable to those of olden times—the main one being that *now* it is customary to send women with complicated labors to an institution which largely, in the former period, were treated at home. Harrar¹⁰ shows this graphically in his report on the deaths in the New York Lying-in. How much is offset by the tendency to treat those complications by surgery rather than by obstetric methods is debatable.

Two complications of pregnancy may be briefly discussed to show how negligible has been the advance in recent methods of treatment. Eclampsia stands out preeminently as a complication which demanded some method of delivery ever since Blundell,¹ in 1834, discussed the advisability of acceleration of delivery, and Carl Braun⁹ popularized it. During last twenty years various obstetricians have improvised operative measures which might accomplish the result with a minimal lapse of time. More discussion has been employed on how to empty the uterus in eclampsia than has been expended on all other phases of the problem. The most evident thing about the question is the paucity of evidence adduced which might elucidate the cause, and then develop a rational therapy. Surgery for eclampsia as the essential part of the treatment is clearly and definitely indefensible. If there be anything to Stroganoff's treatment, it shows most positively that eclampsia is a disease, as popularly treated, which carries a dual mortality—that incident to the toxemia and an equal hazard from the surgical intervention. In Table III, I show that in the preantiseptic days the maternal and fetal mortalities were respectively 20.4 and 33.3 per cent: the modern methods exhibited mortalities of 19 and 39.6 per cent: while in cesarean section in the period covered by modern treatment, the deaths were 34.8 and 25.9 per cent, respectively. Our modern con-

ception of the treatment considers many things other than prompt delivery: really, it was not until 1850 that remedial agents were advocated other than blood letting, and purging. Blundell¹ did discuss, as did others, the use of opium, but many years elapsed before sedatives, anesthetics, etc., became established adjuvants to the therapy. It may be said that the older authorities had no real therapy, yet their results were as good, even better, than ours. In other words, no modern therapy has modified the lethal progress of mother and child with the single exception of that of Stroganoff: a comparison between the results of the latter with the much lauded cesarean operation shows that approximately one baby is saved at the expense of nearly four mothers. I believe Peterson did an unwise thing in his cesarean-eclampsia papers when he attempted to show how many babies might be saved by the operation, and not showing how many were destroyed by the disease; there is a great difference. Eclampsia always has been a fulminating, acute, malady with a high death rate: the operative measures so popularized are carried out on bad surgical risks. Anuria, bowel stasis, anhidrosis, with marked cerebrospinal manifestations, characterize the disease and, as a result, women have died from the toxemia and the operation: likewise, the infants succumbed to the intoxication and the hazards of a forced delivery. Newell² has given ample evidence of the pernicious influence of the teaching that eclampsia demands major surgery.

Mueller³ stated that one half of the deaths from placenta previa were due to infection. The mortality of the mother has decreased one half by cleanliness, not from an improvement of technic, or startling innovation in treatment. Obstetric treatment has not affected the fetal mortality whatsoever, though cesarean section has reduced the percentage from 55.5 to 35.6. Again, the section has not diminished the maternal mortality over approved obstetric methods and, comparing the results of the average cesarean mortality with the findings of such experts as Stratz,⁴ Welte-Pinard,⁵ and Koblanck,⁶ who demonstrate the gifts of skill, we still find that the section kills women in order that babies may be born alive. *A priori*, it would seem that a previa should only be handled by surgery when the woman is a good surgical risk, free from possible contamination, at or near term, the baby definitely alive, and some valid contributory necessity such as a minor pelvic deformity. The advocacy of a routine cesarean for all previas will bring upon the public malign results similar to those depicted by Newell for eclampsia.

I think the facts I have outlined for those two great obstetric complications are sufficiently alarming to warrant your attention. If a comprehensive comparative study were extended to cover a multitude of ordinary accidents of childbirth I am sure data would be presented

which would still further substantiate the general principles I have deduced, namely, that modern obstetrics has not safeguarded child-bearing logically as it should be.

The commonly accepted explanation for the maternal and fetal mortalities as they obtain today is given succinctly in the *Journal of the American Medical Association*.⁷ "Two causes are suggested: ignorance on the part of the public of the dangers connected with childbirth and of the need of skilled care and proper hygiene to prevent them, and the difficulty of securing proper obstetric care * * * and the public still regards childbirth as an entirely normal process and a certain number of deaths are unavoidable. This has reacted on the medical profession, producing low fees, so that, with the exception of the city specialist, obstetrics has become the worst paid, although the most difficult and exacting branch of medicine."

TABLE II
OBSTETRIC RESULTS OF MIDWIVES AND PHYSICIANS OF NEWARK COMPARED*

	MID- WIVES	PHYSI- CIANS	HOSPI- TALS	CITY RATE
Proportions Confined	49%	39%	12%	
Puerperal deaths	10	31*		
Puerperal deaths, women having been given antenatal care, No. 586.	.17%			2.02
Children dying under 1 year of age— 2 year period, per cent	7.07%	7.43%	9.74%	9.74
Children dying under 1 mo.— 2 year period, per cent	2.51%	3.82%	5.73%	
Stillbirths in women receiving antenatal care	.68%			4.17%
SPECIAL THERAPEUTIC MEASURES	MOTHERS DIED	STILL- BIRTHS	DIED IN 14 DAYS	TOTAL
Midwifery data brought down.	.17	.68	2.51†	3.19
Routine Version: Cases 1113 (1a)	.179	3.7	3.05	6.7
Routine Version: Cases 200 (1a)	1.5	9.5	6.5	16.
Routine Dilatation by bags: Cases 200 (1b)	1.	1.	5.	6.

*Levy, Julius: Am. Jour. Obst., Jan. 1918, p. 41.

Routine version: Am. Jour. Obs. and Gyn., Mar., 1921.

Routine version: Ibid.

Routine dilatation by bags: Ibid., Oct., 1920.

†30 days.

No one may refute the correctness of the views here quoted in so far as they go, but many other factors have their determining influence. Ignorance and credulity as regards medical matters are dominating characteristics of the lay mind, but just these elements are clay to be moulded by altruistic physicians in educating the public. Patent medicines and spurious medical cults have their success assured by playing upon these weaknesses of the public. The public wants something better: the public may believe now and then death awaits at the door of the confinement room, but it wants that incidental demise to occur elsewhere than in its own home: if the public knew

the solution it certainly would have it to ward off the evil. The crux of the problem lies within the education of the profession and there is no need of an endeavor to place the onus upon the ignorant public.

The rise and fall of the efficiency in judgment of the general practitioners in their obstetric work are reflections of the attitude and efficiency of the obstetric teachers: and by teachers I mean not only pedagogic members of college faculties, but also contributors to current medical literature. The former and the latter may be one, but from the fact that one may be a professor in an approved medical school gives added dignity and weight to his utterances, and therefore, will be more dangerous from that fact if his teaching be faulty. With a few possible exceptions, probably the quality of the teaching of our colleges is as defective as Williams⁸ found it some years ago. A few maternities have expanded since Williams prepared his paper: largely, they are still inadequately equipped, with insufficient capacity for proper teaching, or for developing the clinic experience of the teachers themselves. What may one expect of the average teaching force other than it will give inadequate and faulty instruction: that its mediocrity in experience and capabilities will be reflected in the mediocrity of thought and attainment and ability on the part of the students faultily trained. Too often teachers do not instill into their students the breath of conservatism, of sound thinking, of deductive reasoning, so later, as physicians, they grasp at the most nonsensical recommendations. We all can recall our student days when the professor who gave spectacular clinics was more popular than he who conducted his clinic without ostentation: in many of our principal colleges the obstetric clinic of the present is too largely the pyrotechnic exhibition which characterized the older surgical arena. An aggregation of complex, unusual problems are presented, leaving scant time for the ordinary run of obstetrics, such as will be indispensable to the student as a practitioner. Certainly a clinic which gives a student 18 major obstetric operations in his two weeks' practical training has misappropriated the student's time. The modern trend in obstetric teaching interferes with a student's perspective: a student who sees an array of heroic surgery out of all proportion to his practical clinic and didactic work, is so befuddled that he naturally conceives that nearly all cases need intervention. Then again, the student's perspicacity may discern that the professor's indications are weak—but later, as a physician, he will do likewise, backed by eminent authority.

The contributions to the literature are the postgraduate instruction of men in active practice. The authors are the bell-wethers of those who read and learn: these writings may be the guides to the thoughtful to a better understanding, and to a more perfect solution of the difficulties which constantly arise in practice or they may be merely

TABLE III
ECLAMPSIA MORTALITIES

REFERENCES	PERIOD	NO.			NO.		
		MOTHERS	DIED	%	CHILD	DIED	%
Ramsbotham: Murphy Mid.	1840	43	3	6.9	53	18	33.9
Collins, R.: 1862 p. 698.	1835	30	5	16.6	32	18	56.2
Hardy and M'Clintock: Ibid.	1857	13	3	23.	13	6	46.1
Sinclair and Johnson: Ibid.	1847	63	13	20.6	69	23	33.3
Mme. LaChapelle: Ibid.	1821	8	?	?	8	2	25.
Arneth: Ibid.	1849	13	4	30.7	13	6	46.1
Braun, C.: Gynec., p. 833, 1881.	1878	73	20	26.	73	15	20.5
Totals: Before antiseptic era.		235	48	20.4	261	88	33.3
<i>Modified Expectant Methods</i>							
Dührssen: Eclampsia; Winckel's Handb. d. Geb., ii Tl. 3.		80	30	37.5	80	60	75.
Friedman, B.: Ibid., p. 2411.							
Goedecke: Ibid., p. 2412.	403	69	17.1	403	194	48.	
Franz: Ibid., p. 2421.	17	2	11.8	17	5	29.4	
Sommer: Ibid., p. 2421.	16	6	37.5	16	10	62.5	
Jardine: Ibid., p. 2423.	22	6	27.7	23	13	56.3	
Sturmer: Ibid., p. 2423.	43	5	12.2	?	?		
Mangiagalli: Ibid., p. 2423.	18	1	5.5	?	?		
Stroganoff: Ctb. f. Gyn., 1910, p. 756.	400	26	6.6	360	77	21.6	
Lichtenstein: Arch. f. Gyn., 1911, p. 183.	400	74	18.5	371	144	38.8	
Hammerschlag: Op. Gyn., p. 433.	8	3	39.	?	?		
From R. Peterson, Am. Jour. Obst., 1911, lxiv, p. 1.							
Bumm-Liepman: Ibid.	90	28	31.1				
Esch (1904-5): Ibid.	79	20	28.8				
Esch (1905-6): Ibid.	145	42	28.9				
Glocker: Ibid.	9	3	33.3				
Möhlmann: Ibid.	10	1	10.				
Winter: Ibid.	8	3	37.5				
Zweifel: Ibid.	49	16	32.6				
Totals: Modified expectant cases.	1795	335	19.	1270	503	39.6	
Peterson, R.: Am. Jour. Obst., 1911, lxiv, 9.	530	124	23.4	315*	67	21.2	
Vaginal Cesarean.				530†	282	53.3	
Peterson, R.: Ibid., 1914, lxix, 924.	500	174	34.8	381*	25	6.5	
				481†	125.	25.9	
Cases before 1908.	198	95	47.9	133*	16	12.	
				198†	81	53.3	
Cases after 1908, to 1913.	283	73	25.8	248*	9	3.6	
				283†	44	15.5	

*Results obtained by eliminating children weighing 2000 gm. or those up to eighth month of pregnancy or that were judged to be premature, living or dead: no child was counted which was known to be dead at time of operation.

†We are dealing with a disease having a high mortality, influenced by various treatments, not the dangers of a major operation: i.e., for the sake of comparison it is necessary to add such figures to the infant mortality as will account for the babies not included in Peterson's statistical report.

Maternal mortality has not been ameliorated these one hundred years. Fetal mortality has not been diminished, either. Cesarean section robs the fetus of many of the lethal stresses of forced delivery, therefore Cesarean section saves babies at the expense of the mother.

the occasions for commercializing the writer, who does not exhibit a celerity of judgment in his recommendations. Unfortunately, too often readers are unable to differentiate between the gold and the dross and as a result any one who will report an operation or a line of

treatment, necessary or unnecessary as it may be, for some ordinary or extraordinary indication, will have imitators who pass the bounds of reason. It may be difficult for the average reader to discriminate between fallacy and truth in the writings of a subtle author: for that reason a man of judgment will not rush to print until long, mature experience justifies the exposition of his theme. There have been too many unwise exploitations which were precipitated upon the profession in the hopes, if they proved popular, priority might be claimed. We all recall the fiasco of twilight sleep furor. We all know the dangerous results which came from the thoughtless laudation of the reputed harmless virtues of pituitrin. The pen is reputed to be mightier than the sword, and it surely is more deadly when wielded by the sophisticated writer.

The basic error has crept into the obstetric field that pregnancy and labor are pathologic entities, that childbearing is a disease, a surgical malady which must be terminated by some spectacular procedure. There is too insistent preachment by those who are defending a reign of terror, of promiscuous operative furor, by the argument that women have so degenerated that childbearing is a phase of pathologic anatomy. These discussions have gone so far that practitioners, supported by spurious authority, are operatively interfering when conditions demand a watchful expectancy, or at most some minor intervention—the culpability lies not with the general practitioners, but their sponsors. And no one is doing so much of this needless operative interference as many of our reputed leaders, and they know not the wreck they have wrought, for they hear only the encomiums on their fallacious representations and their misapplied skill. Those who have stopped, looked, and listened have seen and heard the catastrophies which have accumulated in the wake of the false promulgations. I believe there should be a most emphatic declaration that childbearing is *not* a disease, is a normal physiologic function which may develop pathologic aspects and for that reason all women should have a most careful conscientious prematernal care so they may guard themselves and be protected against possible disaster to themselves and their offspring. The general polemic that labor is a species of the torture of the inquisition has been advanced so frequently that many defend most drastic interferences on the score of saving women this horror—that the dread on the part of women of this frightful agony warrants any and all kinds of expedients to relieve them of the various stages of labor, when, in fact, too often these strictures are merely the shibboleths of those who would operate with little or no provocation. In consequence, we see some who claim the great object is to shorten the first stage by the routine introduction of the bag; another, that it is an obstetric crime to interfere with the delicate mechanism of dilatation, but the moment

dilatation is completed, then, the parturient canal must be slashed, and the baby and placenta delivered by high art. Another holds that the baby must be ushered into the world as custom dictates it shall make its mortal exit—feet first; again, we find men who believe the cesarean operation the panacea for all ills and make it a routine procedure. I have been credibly informed that for a woman to be more than six hours in labor brought censure or reproach upon the physician in attendance, in one of the large towns contiguous to Boston. A former student was showing me through a hospital where he was resident: he informed me he was told, as a joke, that the “office hours” was the principal indication for forceps, but when he got on the obstetric service he found it was the plain truth. I have yet to be convinced that the average woman is repressing the reproductive function from the fear of the pangs of labor: the woman who is so loath to assume motherhood on this score probably has such an absence of maternal instinct that her progeny, uncreated, are more happily situated in the *here-to-fore* than made subject to her selfish influence. Those who have studied the situation know full well that sociologic-economic necessity transcends all others in the restriction of families.

In the past, conservative writers arraigned those who did meddlesome midwifery, the vogue of the times being minor transgressions like protracted digital dilatation which accomplished no purpose, titillation of the clitoris for the purpose of exciting pains, or making the hapless woman forget her troubles, pulling on the cord, or too frequent application of the forceps, etc. Meddlesome midwifery has now taken a more serious turn until it comprises all the known methods of necessity, even major surgery, without the vital essence of a valid indication: the favorite rôle being those which will consummate delivery with the minimal expenditure of time. Is it not a parody on modern scientific obstetrics that each advocate of his special form of interference will proclaim results not in consonance with the experience of experts, will declare the simplicity of the procedure is such that all may do it, no untoward effects need be expected, when in our hearts we know their allegations, probably based upon thoughtless enthusiasm, are most egregiously exaggerated? And when these advocates appear before a scientific body, with their spacious claims, all laud their skill, and rarely is one courageous enough to combat the irrational and untenable interference.

It was a natural consequence that all obstetric procedures had their indications widened as their relative safety became established. But that any operation, because asepsis makes it reasonably safe and anesthesia keeps the patient quiet during its performance, should be so inordinately broadened in its scope that the suspicion (no candid admission) is evidenced that it is being done for the convenience and con-

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Kouwer	8	3	37.5	8	3	37.5
Ribbius	98	7	7.1	98	39	40.8
Stratz	57	1	1.7	57	36	63.
Fry	14	0	0	14	5	35.7
Galabin	92	15	16.1	92	69	75.
Hautel	123	12	9.7	123	92	74.1
Hirst	28	0	0	28	24	50
Siebert	24	10	16.8	24	8	33.3
Dorman	84	10	11.9	84	38	45.
Welti-Pinard	149	4	2.6	149	34	32.7
Lomer	236	21	8.9	178	105	60
Drejer	49	2	4.09	50	12	23.5
Platzer	46	4	8.7	46	25	53.2
Zedler	16	2	12.5	16	6	37.5
Higgins	75	8	10.6	?	?	
Rotunda Hospital	74	3	4.	?	?	
Murphy	61	2	3.2	?	?	
Klein	138	13	9.4	?	?	
Schauta	234	16	6.8	234	127	54.
Strassmann	231	22	9.5	231	144	61.2
Driessen	125	19	15.2	125	80	64.
Doranth	216	20	9.3	216	152	70.3
Fournier	7	0	0	7	3	43.
Koblanck	467	18	3.8	?	?	
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Behm	52	0	0	52	30	60.
Totals.	2756	213	7.4	1985	1075	54.1
Jewett: Am. Jour. Obst.	2010	221	10.9	2020	1159	57.3
Behm, omitted, repeated	40	0		40	31	
	4726	434	9.2	3965	2201	55.5
<i>Abdominal Cesareans.</i>						
††Cases collected by Holmes: also 7 babies died within 14 days.	25	5	20.	25	9	36.
Jewett: Am. J. Obs., p. 943, June, 1909.	95	11	11.5	97	37	34.
Davis, Asa, Am. J. Obs., p. 120, Jan. 1915.	21	2	9.5	21	7	33.3
Davis, E. P., Penn. M. J., p. 292, Jan., 1915.	18	0	0	18	7	37.7
Foulkrod: Am. J. Obs., p. 459, Mar. 1913.	4	1	25.	4	1	25.
Doederlein: Cent. f. Gyn. p. 1383, No. 38, 1913.	146	12	8.9	146	44	30.1
Total Cesareans	309	31	10.	311	111	35.6
Obstetric Treat.	4726	434	9.2	3965	2201	55.5
Preantiseptic Period.	1078	229	21.2	1033	554	53.6

*Murphy: Midwifery, 1862, p. 698, et seq.

†Braun, C.: Gynecology, 1881, p. 561.

††Blacker et seq. to Behm taken from table in "Cesarean Section an Improper Procedure," Jour. Am. Med. Assn., May 20, 1905.

servation of time of the operator, is a travesty on scientific endeavor. I feel that the modern trend of obstetric practice has been to apply surgical manipulation to normality to a degree which is not in consonance with refinement of judgment. What is needed is a reformation in the rules and the development of an obstetric conscience which will permit intervention only when intervention is imperatively needed. Strict indication is one thing, but the widespread use of operative interference with no indication except the whim, or plain obcecation of the attendant, has spelt disaster, has retarded the progress of obstetrics, and has fended off the days of conservation of the expectant mother and her unborn child. It is a reproach on the medical profession that a city like Newark may advertise the fact that it is safer to be delivered by a midwife than by a physician or in a hospital.

CONCLUSIONS

1. In safe conservative hands maternal and fetal mortalities have decreased in private practice.
2. The maternal and fetal death rates, in hospitals, have not shown an appreciable decline in one hundred years.
3. The fact that the death rate among the emergency cases (i.e., those sent in by medical attendants) is over ten times that of regular applicants in the New York Lying-in Hospital is a reflection on the preliminary medical training of the profession.
4. Scientific investigation of antenatal pathology which will promote a prophylactic therapy will lower infant mortalities more than the present attempts to do so by routine operative termination of labor.
5. A properly conducted prenatal clinic, combined with conservative conduct of labor is a more certain method for securing declining death rates than promiscuous intervention.
6. Under normal conditions, spontaneous labor, aided by proper analgesia, is the safest way for mother and child. Inordinately applied operative interferences increase the hazards of birth.
7. The authorities who have fostered a peculiar method of routine interference in all parturient women, with their imitators, have retarded the advance in obstetric care, and are part contributors to the high American mortalities incident to childbirth.
8. It is a lamentable thing that properly controlled midwives will have less mortality than those who practice a routine intervention.
9. The proponents of operative cults have produced no evidence to show that their systems are more worthy, less risky, and promise a higher conservation of life than carefully watched spontaneous labor.
10. There are no more reasons why all parturient women should be delivered by operation than that all people should be inflicted with routine enemata or catheterization.

11. A medical fad should be discountenanced: precept and example founded on injudicious enthusiasm lead to many unwise courses.

12. Indications for obstetric operations demand revision: certainly, they should be more clearly drawn and curtailed, rather than extended.

13. A wise conservation in obstetrics will be more productive of ideal results than injudiciously used skill.

14. Obstetric teaching is so deficient in most colleges that there should be a sharp and early improvement: so long as obstetric teaching is defective so long will obstetric results be bad in practice.

15. An obstetric curriculum should be devoted to practical instruction on the mannikin, in the class room, and in the clinic; obstetric surgery should be a very small part of the coordinated whole. The proper place of the latter is in postgraduate courses intended for those preparing for the specialty.

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(For discussion, see p. 297.)

FORCED LABOR; ITS STATUS IN OBSTETRIC TEACHING*

BY JOHN OSBORN POLAK, M.Sc., M.D., F.A.C.S., BROOKLYN, NEW YORK

FOR the purpose of this discussion we shall consider the comparative status of such procedures as:

1. The induction of premature labor in contracted pelves, with a conjugate vera of 8.5 cm. or more.

2. The induction of labor at estimated term in normal pelves by the introduction of the bag, bougie, or vaginal pack.

3. Procedures for the shortening of the course of the second stage of labor, such as the use of pituitary extract or of routine forceps when the head is below the spines, or on the pelvic floor, and the cervix is fully dilated, with deliberate discission of the outlet soft parts.

4. Measures which entirely eliminate the second stage of labor, as elective internal version, and elective cesarean section, and finally:

5. Hurrying the third stage by the immediate and forcible expression of the placenta, with the first uterine contraction.

It would seem that it is time for us as a Society, composed of the leading obstetricians of this country and Canada, to formulate certain

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