MISMANAGED LABOR THE CAUSE OF MUCH OF THE GYNECOLOGICAL PRACTICE OF THE PRESENT DAY.

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THE comparatively recent and rapid growth of gynecology into a specialty is no less surprising than the brilliant and wonderful results which it has achieved.

Painful and disgusting accidents, the effects of which formerly doomed unfortunate sufferers to lingering lives worse than death itself, are now completely cured, and conditions which years ago were hardly treated at all are now successfully operated upon.

Contemporaneous with the development and successful growth of gynecology into a recognized specialty, there has occurred in the civilized world a much greater proportion of uterine diseases than was ever known to exist before.

Whether this increase in the development of diseases peculiar to the female has been discovered by a greater skill than previously existed, or whether the ever-changing modes of life, especially among the higher and more civilized classes of society, has, in this age, favored their production, or whether the study of gynecology and its brilliant achievements has for a time blinded the eyes and hardened the hearts of the profession to such an extent as to lessen interest to a considerable degree, and suspend research into the sister — or, perhaps, more filially speaking, mother science of obstetrics, it will be the province of this paper to discuss.

While there may be a certain quantum of truth in all of the causes mentioned, especial reference will be made to

the last, as one of the principal, if not *the* principal cause of the increasing number of cases applying to the gynecologist for aid.

It has come to be a saying, nowadays, that it is as difficult to find a perfectly healthy woman, as it was for Diogenes, in his day, aided by his lantern, to find a perfectly honest man.

While the brilliant and ambitious in this department of medicine are acquiring reputations for the frequency and skill of their operations, it would almost appear as if the great science and art of midwifery was being left to the general practitioner and midwife.

That the tendency of writers and investigators is markedly in the direction of gynecology, we have evidence in the transactions of obstetrical and gynecological societies, and even in the obstetrical journals of the day.

In the first volume of our Transactions there are twenty-one articles of great interest, but only five of them relate to obstetrics.

Out of the twenty-seven papers in our second volume two only relate to obstetrics; and of the twenty-three articles in our third volume nine are upon obstetrical subjects.

A similar amount of space is occupied in our obstetrical journals by gynecological subjects.

In the July number of the "American Journal of Obstetrics," very ably edited by one of our Fellows, there are forty-three separate and distinct papers or extracts, and only twelve of those papers are upon obstetrical subjects, and some of these relate solely to the fetus.

In the "British Obstetrical Journal" for July there are eighteen separate papers and discussions, and by a liberal count we find ten of them relating to obstetrics.

It might be pointed out as the chief reason of the fact, that, of the seventy-one articles in our three volumes of transactions only sixteen are upon obstetrical subjects, that ours is mainly a gynecological society; but while the *name* is prominent, our constitution declares equally in favor of all that relates to gynecology and obstetrics.

This reason could not be urged by the journals whose name would indicate that they were chiefly devoted to obstetrics.

In the sixty-one articles of the American and British Journals of Obstetrics for July we find only twenty-two discussing obstetrical subjects.

This subject is referred to simply to illustrate the force and meaning of my statement, that the tendency is to the newer field of gynecology, to the neglect of the more important department of midwifery,—more important, because, while in the former we render our patients much more comfortable and at times prolong life, in the latter, by our operations and skill, we not only save maternal and fetal life at the time, but by wise treatment and operative procedures we *prevent the necessity* of our patients calling upon the gynecologist in the future at all, by preventing the occurrence of those conditions requiring their aid.

The object of this paper is to draw attention to the fact that gynecology derives much of its prominence and importance from the mismanagement of obstetrical cases and their faulty treatment during the puerperal month.

Every obstetrician sees cases, in consultation, which have been so mismanaged from the start as to render him powerless to prevent subsequent damages to maternal structures, or, perhaps, to save life.

There is a growing tendency among general practitioners in the direction of assuming the responsibility of severe obstetrical operations and treatment without skilled counsel which is not apparent in the field of gynecology.

The latter branch, as a specialty, together with ophthalmology, laryngoscopy, dermatology, and microscopy, have by their improvements and instrumental armamentarium outgrown the skill and knowledge of the family physician and surgeon, so that there is less unwise and unskilled tampering with these branches of our science than with obstetrics. Severe cases in these and other departments are either sent at once to experienced specialists, or their aid in diagnosis and treatment sought.

Unfortunately for the patient this is not so much the case in the practice of midwifery, and gynecology waxes great in the land from the necessity which exists for curing cases owing their origin to mismanagement during abortion, confinement, or the puerperal month.

The experienced accoucheur is not always able to avert danger, damage, or death.

If this be true of those who give all their time and talents to the study and practice of midwifery, how much more is it true of those who occasionally attend cases of labor, and who do not possess later obstetrical authorities or read obstetrical journals.

In the matter of the faulty management of patients during and after miscarriage, we have abundant evidence, from its recorded fatality in private practice, its direct and indirect agency in the causation of uterine disease, and in our dispensary records, of the proof of my statement.

Dr. Lusk, in a paper upon this identical subject, read before the New York State Medical Society in February last, stated that "death from faulty management of abortion was by no means of unfrequent occurrence, — the deaths from this cause reported between the years 1867 and 1875, inclusive, to the Bureau of Vital Statistics in New York, were one hundred and ninety-seven, — a number which falls, in all probability, considerably short of the truth, by reason of the many circumstances which, precisely in this condition, tempt to concealment." "The total number of deaths, during the same period, from metria, were nineteen hundred and forty-seven."

"Hegar recorded one abortion to every eight or ten full deliveries, a proportion which, if correct, would seem to show a mortality from abortion hardly second to that of puerperal fever itself."

"In addition to fatal cases, the large amount of uterine disease traceable to bad management at the time of abortion contributes still farther to the grave responsibility which rests upon the physician; and yet, excluding cases of criminal malpractice and willful neglect on the part of

the patient, an abortion, unless it occurs as a complication to otherwise dangerous diseases, ought to be free from peril."

Criminal abortion has in it many of the elements of danger. The haste and lack of anatomical knowledge on the part of criminal abortionists, the necessity of secrecy, and attempts to avoid exposure, together with the patient's remorse of conscience, all conspire to make the practice peculiarly a dangerous one.

M. Tardieu has found that of a hundred and sixteen cases of criminal abortion, of which he was able to ascertain the termination, sixty died.

In hospital practice, where patients are under direct control, deaths rarely, if ever, occur.

Dr. Johnston reports that during his seven years mastership of the Rotunda Hospital there were two hundred and thirty-four cases of abortion. One of these died, but it was from mitral disease of the heart.

The history books of Bellevue Hospital show a similar clean record.

That like favorable results have been obtained in other hospitals, and by many physicians in private practice, I have no doubt.

Dr. Lusk says he has "nothing but words of praise and honor for those who have contributed so much, in the past ten years, to perfect the practice of gynecology." He "regrets, however, that the flattering interest their labors have excited, has tended to weaken interest in the sister department of obstetrics," and says that "while our young men seem all desirous to make a specialty of the diseases of women, it is hard to obtain a hearing for the statement of the very trite fact that it is faulty midwifery which gives to gynecology nearly all its importance."

Leishman, who, upon the whole, favors the temporizing and expectant method of treating cases of abortion, in which the placenta and membranes are retained, says, as he sums up his remarks: "We are convinced, from long experience, that no more fruitful source of menstrual dis-

orders or chronic uterine disease exists than what arises from a want of due precaution at this critical period of a woman's existence."[1]

Priestley, of London, strongly insists on the removal of the placenta and membranes as soon as possible after the expulsion of the fetus; and Playfair says, "a patient can never be considered safe from septicemia with them still in the uterus," and adds, that "the frequency with which abortion leads to chronic uterine disease, should lead us to attach much more importance to the subsequent management of the patient than has been customary."[2]

Two or three rash and unskillful practitioners in a city, who have somehow grown into a large midwifery practice, but who have failed to learn by experience, have been known to keep a gynecologist busy in treating diseases and repairing damages which greater obstetrical skill might have prevented altogether, or greatly lessened in severity.

Many of the fistulæ which come to us for operation, it has been demonstrated by Emmet and others, are produced by too long pressure during the second stage of labor, and should have been prevented by a timely use of the forceps; likewise, much of the pelvic cellulitis, and many contusions, and lacerations of the cervix.

Improper treatment at the time of labor, or the neglect of any management whatever during the puerperal month, brings to our offices many cases of uterine displacement, subinvolution, chronic cystitis, laceration of the cervix and of the perineum.

The failure either to prevent the occurrence of some of these conditions, which is quite possible with proper care, or to *operate at once* for their relief, has entailed endless trouble, pain, and expense upon the pitiable subjects of this practice, and brought them, after years of suffering, to the gynecologist for that aid which should have been rendered before they left the hands of the obstetrician.

It is true that many of the slight lacerations of the va-

[1] Page 385, 2d ed. [2] Pages 240, 241.

gina, perineum, and vulva are not detected at the time of their occurrence, or subsequently, and that they heal completely without any treatment whatever, and that by appropriate treatment many such conditions are induced to heal and all evil consequences averted. This is, unfortunately, not always true.

I have, time and again, seen symptoms which have greatly alarmed the family physician and friends, quickly and completely disappear under the use of antiseptic vaginal and uterine injections and antipyretic doses of quinine.

Putrid discharges were permitted to run over abraded and lacerated surfaces, without even an attempt at purification with warm water injections.

I have been able to surmise correctly the cause of the difficulty in cases where I have been honored by a request to assist in the treatment, upon opening the front door of the patient's house. An unmistakable odor pervaded the entire establishment, and yet the nurse, and sometimes the physician, would explain that the patient was frequently cleansed, and would attribute her chill and febrile condition to the exposure consequent upon their efforts to preserve cleanliness, little dreaming that she was the victim of the absorption of septic material lying in and blocking up the bruised and lacerated vagina.

While it may be true that abraded surfaces protect themselves, after a few days, by the deposit of lymph and by granulations, thus practically abolishing the absorbing surface, and that the discharges rarely become putrid for two or three days, yet patients from whom these foul smelling discharges take place are wonderfully relieved from their grave symptoms by antiseptic vaginal and uterine injections, good nourishment, and pure air.

Referring again to the subject of abortion, I have been unable to overcome the objections of the family physician, in a case where we removed a partially putrid placenta forty-eight hours after a four months' miscarriage, to the use of antiseptic uterine injections. The placenta had been cleaned off mostly in one piece, with the fingers placed

through the cervix — the patient etherized — while the remainder was removed in small pieces; some portions of it undoubtedly remained behind, together with small coagula, and the uterus should have been gently washed out and disinfected. But the doctor fearing to use intra-uterine injections none were allowed. Considerable ergot had been previously administered, with the hope of provoking the uterus to expel its contents, and reliance was placed upon its continued action, together with the dynamic force excited into play by the manipulation, to secure the evacuation of the remaining portions of the secundines and blood clots. The woman fortunately escaped septicemia. She had, however, several chills, a temporary elevation of pulse and temperature, and a slow convalescence, which the doctor attributed to the shock of the operation for the removal of the afterbirth, and to her loss of blood.

The best treatment of the third stage of miscarriage or abortion, is a most important subject, and one upon which, unfortunately, there exists a very wide difference of opinion. There are probably few who have attentively studied this subject who would consider a patient safe after an abortion until the placenta had been expelled, or who would hesitate to dilate the cervix, if necessary, and remove it after waiting a reasonable length of time; they would condemn the practice of acting upon the old obstetrical dictum that there was more risk from manipulation necessary for its removal than would arise from its detention for an indefinite period within the uterus.

Without quoting from obstetrical text-books, I think it will be admitted by all present, familiar with the opinions of obstetric authors, that, until quite recently, the weight of authority was upon the unsafe side of this important question; that delay was counseled, and manipulation for the removal of the retained placenta discouraged or forbidden.

I am as certain as I can be, without absolute proof, that the lives of many women have been saved when threatened by chills, high pulse and temperature, associated with a

putrid discharge, by removing the retained placenta, and washing out the uterus with antiseptic fluids.

I have known of several deaths which, I think, could have been prevented, where the placenta was not delivered at all, but "left to nature," as Meigs and Puzos, of Paris, advised, with the hope that it would be finally discharged or absorbed, if that is possible, or that the putrid discharge would do little harm.

With my comparatively short experience I have met many physicians in practice, and in discussing this subject, who favored leaving the placenta and membranes undelivered in cases requiring a redilatation of the cervix, and manipulation for its removal; and Dr. Thomas, our honored president, remarked, when discussing this point in the New York Obstetrical Society, February, 1878, "that when the subject lately came before the New York Academy, he was not only surprised, but a little shocked, to find so many men who were in favor of allowing the placenta, as a rule, in these cases to remain undisturbed."

Many of the women thus treated, who finally escape the undertaker, sooner or later require the services of the gynecologist for relief from fibroid tumors, subinvolution, uterine displacements, chronic metritis, metrorrhagia, and leucorrhea, combined with anemia and vitiated health. The effects of prolonged pressure, during the second stage of labor, in producing cellulitis, cervicitis, and sloughing of maternal parts, are too familiar to require more than a mere mention. These troubles pass frequently from the hands of the accoucheur to those of the gynecologist, and could, in some cases, have been prevented altogether by either a timely use of the forceps or by other appropriate means.

I have seen several cases in consultation where too early rupture of the amniotic sac and irritation of the cervix by too frequent digital manipulation had changed a labor which was progressing well (although a little slow) into a prolonged dry labor, with a rigid cervix, requiring, in one instance, craniotomy, and in three others difficult forceps operations, accompanied, in one case, by laceration of the

cervix down nearly to its junction with the vagina, and in the other two by such a slow convalescence as to bring them within the range of gynecology.

Uterine troubles, I believe, too frequently result from the tonic rigidity of the uterus during labor, produced by the unwise and excessive use of ergot. The uterus, as well as the patient, becomes rapidly exhausted under ergotism. This condition is not always recognized, and more ergot is administered to whip the already overworked organ into more rapid and powerful action. Not only is the child frequently sacrificed by this treatment, but work prepared for the gynecologist in future.

Portions of the secundines and blood clots left in utero, when the afterbirth has been removed by pulling upon the umbilical cord or tearing it away with the fingers, have been the cause of septicemia, metrorrhagia, obscure hemorrhages, and fibroid tumors, which have called for treatment months after the attending physician has ceased his visits.

Gynecologists in charge of female clinics, if their experience is similar to mine, trace the cause of many of the diseases for which women apply to them for treatment, back to too early resumption of their avocations after abortion or confinement, or to mismanagement of the third stage of labor.

While some women are undoubtedly benefited by an earlier sitting up than the customary nine days, when under such constant and able control as they receive at the Preston Retreat, and can ride about and walk out in two weeks after confinement, many women, and perhaps the majority, are injured by it.

The fact remains that involution is not completed until the expiration of about six weeks,[1] in healthy women, and all the conditions favoring subinvolution and uterine displacement being present many such cases occur.

The colored women of the South are pointed out as re-

[1] The paper just read by Dr. Sinclair, of Boston, giving a large number of measurements of the uterus within the puerperal month, made by himself and Dr. Richardson at the Massachusetts General

markable examples of early getting up after delivery, and the fact emphasized that nine days in bed produces debility and prolongs the period of convalescence, and that the puerperal month is shortened from one to two weeks by them with advantage.

In a considerable experience at one of the Freedmen's hospitals, after the late war, I had an opportunity to test the truth of this theory.

Many of these women could be kept in bed but a few days, and would stand, walk, go up and down stairs, attend to their children, and perform other light duties within a week or ten days after confinement. They were impatient of control, thought our rules regarding cleanliness and quiet unnecessary, adhered to their time-honored custom of early getting up, and often eluded the watchfulness of the nurses.

In the dispensary service attached to this hospital I had abundant opportunity to witness the effects of this practice. Patients suffering from the effects of subinvolution, uterine displacements, and hemorrhage, presented themselves for treatment more frequently than for any other ailments.

The process of involution is interfered with or arrested by uterine displacements, and the consequent disturbance of the uterine and pelvic circulation is a prolific cause of the hyperplasias, hypertrophies, chronic cystitis, and general pelvic irritation which we have so much difficulty in relieving.

It is precisely this class of patients who pass unrelieved from the care of one physician to another, until they finally fall into the hands of an experienced gynecologist, who recognizes the primal origin of their protean maladies, and, by appropriate treatment, heals them.

What has been said already, applies to the faulty man-

Hospital, would seem to disprove the views heretofore held by the profession upon this point; indicating that involution is completed in less than half the time that has been supposed to be occupied by that process.

agement of miscarriage and natural labor and its subsequent fruits.

For a number of years I have been an earnest advocate for instrumental aid to women who presented symptoms denoting failure of their vital powers, danger to their soft parts or to the life of the child, or the other recognized symptoms calling for the aid which the forceps can render.

I have delivered children, who were threatened with death from the effects of ergot wrongfully given, when the mother gave no evidence that she needed the forceps. I believe we should prevent damage to the maternal structures by their use, as well as assist patients out of positive dangers by which they have been some time environed.

The forceps, when used by a skilled hand, I have contended, was capable of more good to the human race than any other instrument used by the profession. More lives are saved, and more calamity averted by its skillful use than by any other one instrument, and yet, holding this idea with pride and tenacity, we cannot close our eyes to the fact that the bungling use of this wonderful instrument, by hasty and inexperienced hands, is liable to bring, and has brought, discredit and distrust upon it.

Gynecologists are treating cases constantly the beginnings of which date back to a forceps operation badly performed by an inexperienced physician.

The manner of applying the blades, the direction and extent of the tractive force required in individual cases, the length of the interval between the times of application of this *vis a fronte*, the management of the perineum and the removal of the blades, the control of the uterus for the prevention of hemorrhage and expulsion of the placenta, are all points which cannot be learned in a day or by a few trials.

The growing sentiment in favor of the frequent and early resort to the forceps, while it is fraught with happy results when used by men of skill and experience, is, I fear, destined to abuse, and present as well as future evil, when used indiscriminately in general practice.

When we consider the effects of lack of skill and experience in the performance of the high forceps operation, — the "supra-pelvic operation," as Barnes has recently called it, — we are led at once to give assent to the fourth proposition of Barnes, in the discussion just closed in the London Obstetrical Society, namely, "that in proportion as the head was arrested high in the pelvis, in the brim, or above the brim, the necessity, the utility, and the safety of the forceps becomes less frequent," and to agree with Braxton Hicks, that the above is a self-evident fact, and "as a corollary from the preceding propositions, increasing caution in determining on the use of the forceps, and greater skill in carrying out the operation, are called for."

Dr. Roper makes a point for me in the same discussion.

In his experience, both hospital and private, he had attended twelve thousand labor cases, and was profoundly impressed with the necessity of skill and great care in preventing danger from the too frequent use of the forceps by the *accoucheur*. He then referred to the frequent use of forceps in *ordinary practice*. He said "many practitioners were in the habit of taking forceps with them to every case of midwifery, and whenever any delay took place the forceps were forthwith applied without the existence of any factor of difficulty. The instrument could not be said to be used in such cases in the interest of either mother or child; the best that could be said in favor of such practice was, that it diminished the duration of maternal suffering, and this it might do, but against this diminution of prolonged suffering of a slight kind, must be placed the intense pain of rapid delivery by the forceps, the risks of injury, post partum hemorrhage, trouble with the placenta, and the after effects of subinvolution, caused by not allowing the uterus to do its own work."

He "could not help thinking *that much of the gynecological work of the present day resulted from this frequent interference with the natural functions of the uterus in childbirth.*" [1]

[1] Italics mine.

Dr. Goodell tells us, in his "Lessons on Gynecology," when speaking of the prevention of uterine disorders, that, "to stamp them wholly out may be impossible, but the alert physician can do much toward balking their approach."

It is quite as evident that injury is done the maternal structures in version and craniotomy, when performed by the tyro, as in the forceps operation.

I have seen rupture of the cervix produced by the hasty thrusting of the hand and arm of the operator through an irritable and partially dilated *os* for the performance of podalic version in a case of placenta previa.

Instead of rupturing the membranes and plugging the cervix with a dilator, encouraging uterine contractions, and awaiting the dilating process, — standing ready to act more effectually if the present state of the patient required it, — version is frequently attempted too soon, and before the very vascular and almost pathological condition of the cervix would permit the entrance of the hand.

The hemorrhage being the chief element of danger, when that is under control, and the presenting part of the child can be converted into a tampon by Hicks' or our own Wright's [1] method of combined external and internal manipulation, the patient is saved from the dangers of podalic version.

I know of at least two cases where women were rescued from the dangers of placenta previa, only to die from uncontrolled oozing of blood from lacerations in the vascular cervix; and many cases are upon record of metritis, phle-

[1] Dr. Marmaduke B. Wright, of Cincinnati, an Honorary Fellow of our Society, who has died since our last meeting, contested with Braxton Hicks, of London, the priority of operating, and published descriptions of version by combined external and internal manipulation. According to published correspondence between them just previous to the death of Dr. Wright, it appears that both these distinguished gentlemen wrote and operated upon nearly the same identical plan at about the same time. Hicks gives to Wright due credit now, but says still that he tried to accomplish the same ends proposed by Wright, but by a slightly different order of manipulation.

bitis, phlegmasia dolens, cervical lacerations, and like injuries produced by the hasty, unwise, unskillful, and unnecessary turning operations for the relief of placenta previa.

A less vigorous, rapid, and forcible course of procedure in these dangerous cases, when seen where labor is in actual progress, and by the gentle induction of premature labor in cases clearly diagnosed, after the viability of the child, would, I am convinced, lessen the frightful mortality in placenta previa and rob the gynecologist of the subsequent necessity of repairing the damages of the attending physician.

Version, forceps operations, and craniotomy, done in a contracted pelvis, often result in damage to the soft parts. The risk, however, is necessary, and is less than the certain danger of remaining undelivered.

The slipping of the perforating scissors, and the removal of spiculæ of bone by Meigs' craniotomy forceps, have produced such injury as to give the patient little choice between Scylla and Charybdis.

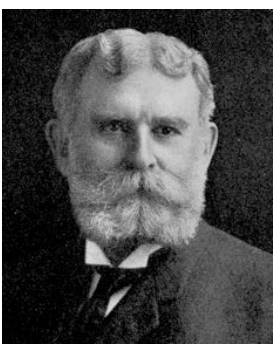
It might formerly have been considered the least of two evils, but by the use of the curved trephine, cranioclast, and cephalotribe, these dangers are greatly lessened.

A patient is entitled, when undergoing the agony and enduring the exhaustion of a lingering or difficult labor, to the best of skill and to the most improved instruments; and that physician who attempts the performance of the capital operations in obstetrics without these necessary factors of success assumes a very grave responsibility.

Without further amplification of a subject which might be indefinitely elaborated, and from which, in abler hands, many valuable lessons might be deduced, I will close this paper by urging a greater study of obstetrics, its clinical teaching in our colleges, including the idea so emphatically stated by the President in his address yesterday morning, that no physician should allow a patient to pass from his care in a condition to develop any of the diseases which I have alluded to, as a means of preventing many of the conditions which we are called upon to treat in gynecology.

DISCUSSION.

THE PRESIDENT, DR. T. G. THOMAS. — We have listened with interest to Dr. Johnson's valuable paper. It is now open for discussion, but our time is so limited, and the number of papers remaining to be read so large, that, without discourtesy to him, I feel under obligation to call for the next paper on the programme. Dr. Johnson's views have my hearty approval and endorsement, as I know they have of all the Fellows of the Society.



Joseph Taber Johnson
(1845-1921)

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Born in Lowell, Mass., June 30, 1845. Founder. Secretary, 1886–1890. Vice-president, 1891. President, 1899. Council, 1881, 1884, 1896, 1899–1901. Honorary Fellow, 1915.

Honorary degree A.M., Columbia University, and Ph.D. Georgetown University. Medical department of Georgetown University, 1865. Bellevue Hospital Medical College, 1867, and in Vienna in operative obstetrics, 1871.

Acting assistant-surgeon in the United States Army in 1868–1872. Professor of obstetrics and diseases of women and children Howard University, medical department, 1867–1872. Gynecological surgeon to Columbia Hospital in 1892. Gynecological surgeon to Providence Hospital, 1884–1894. Consulting gynecologist to the Emergency Hospital and Central Dispensary since 1890. Professor of gynecology and abdominal surgery in the University of Georgetown, medical department, since 1874.

Member of the Medical Association of the District of Columbia, Medical Society of the District of Columbia, president, 1890; Washington Obstetrical and Gynecological Society, American Medical Association. Fellow of the British Gynecological Society, Southern Surgical and Gynecological Association, president, 1899. Honorary fellow of the Massachusetts Medical Society and of the Medical Society of Virginia. President of the Woman's Dispensary and Hospital since 1884, and of the medical department of the University of Georgetown.

In January, 1914, severed all professional connections and moved to his country home in Cherrydale, Virginia.

Died, March 12, 1921.