SHOULD OBSTETRICS BE STANDARDIZED IN ACCREDITED HOSPITALS?

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I. OBSTETRIC MORTALITY

THE mortality rate in obstetrics is ever increasing. What is wrong? Where is the cure? The rich and the very poor receive the best obstetric care, while the great majority of so-called "middle class" women continue to pay with their lives and health the high mortality rate. The American people are too intelligent to allow such a disproportion to continue unnecessarily. The public has established hospitals and given freely of money, yet the mortality rate in obstetrics is not decreasing. Where is the cure?

II. PART PLAYED BY MEDICAL PROFESSION

A. During the past two decades there has been a feverish attempt, on the part of physicians, to advance the science of medicine. Obstetrics has shared in this "advancement," yet our mortality rate does not show it. These attempts at improvement are commendable, perhaps, if we retain and apply with the innovations the fundamentals in our field. There have been many new and ingenious modifications of instruments, changes of procedure, increased knowledge of drugs and their action. Is it a true advancement of obstetric science for the general practitioner to be informed that a dangerous drug can be packed in the nose with a degree of safety when our leading obstetricians teach the dangers of the same drug when administered in careful dosage by hypodermic? The fact remains that the dangers to the mother and baby are only multiplied unless our new inventions are most intelligently applied.

In 1918 all class A medical schools required that their seniors receive at least one year's training in an accredited hospital. Did these interns, during this one year's training, receive the best in obstetric teaching or were their ideals of the class room shattered? The answer is found in our maternal death rate, which is higher now than it was ten years ago when this system of intern training was installed.

B. Procedures which are helpful. Medical schools are giving us more thoroughly prepared interns each year. The large clinics associated with the schools have demonstrated to the student, to the physicians, and to the public at large that good results can be obtained by practicing good obstetrics. The Maternal Welfare Committee has through its organization focused the attention of physicians in general to the obstetric situation, awakening a new interest in the responsibility of physicians to the pregnant woman.

III. PUBLIC

A. The action of the Maternal Welfare Committee in dividing the country into districts and placing over each district one or more physicians, interested in better obstetrics, has been a forward step in educating the public and physicians. The American Child Welfare Organization through its publications carries a note of sincerity, which will convince the people. Local lay organizations and women's clubs are beginning to discuss obstetrics. Nearly all state governments distribute free literature on maternal and child welfare. Most state laws require birth and death registrations, and nearly 90 per cent of the nation is in the registration area. Many states require certain standards, none too high, that hospitals must maintain before they are permitted to conduct a maternity service. The elimination by the state of small maternity hospitals established in old homes with inadequate facilities has helped reduce the mortality rate. The National Government maintains its department on maternal welfare. Excellent publications and advice to the public on prenatal care are freely distributed. The passage of the Sheppard-Towner Act, right or wrong, is intended to lower the maternal death rate. With all this publicity our patients are rapidly becoming informed of the possibilities, both good and bad, which may occur during the act of reproduction. The public has been advised and still is being advised that the well-organized hospital is the safest place for confinement.

IV. HOSPITALS

On the advice of physicians, the public has established and equipped many hospitals. In 1873 there were but 149 hospitals in this country. In 1923 there were 7095, an increase of 4661 per cent in the brief period of fifty years. On March 24, 1928, there were 6807 hospitals and sanitariums recognized by the American Medical Association as "a safe place for such service as they purport to render." Of this number there are 609 hospitals approved for intern training. We are rapidly reaching the saturation point for hospitals. Further development must be along the line of individual hospital improvement, and more efficient organizations of the respective services rendered.

The conduct of medical service has been left nearly in its entirety to the physicians, but let us not forget that these institutions belong to the public and must serve the needs of the public and not the convenience of the physician. So long as we direct the service in these hospitals to the best of our ability, we shall receive only cooperation from the public. The public rightly feels that the hospitals, through their administrative officers, will see to it that patients receive the best possible treatment. It is a serious obligation which we, as physicians, must help the hospital fulfill.

Another obligation the hospital must perform is the training of fifth year medical students. The hospital is required to furnish, through designated members of the staff, "adequate instruction and experience in the various branches of medicine to these interns, especially, emphasizing obstetrics and pediatrics." If our obstetric standards in these hospitals are not in keeping with the previous instructions of these interns, we are doing the intern, the hospital, the public, and ourselves an injustice, for the young man learns a new but inferior kind of obstetrics.

V. REVIEW OF OBSTETRIC HISTORIES

A. Number of cases. After reviewing personally all of the 1927 obstetric histories from three hospitals designated for the training of interns, certain features of the service seemed to me to require further study for improvement. The total number of cases delivered were 883, all having reached the seventh month of pregnancy. Obstetricians (physicians especially interested in obstetrics) delivered approximately half or 428 of these patients. General practitioners delivered the remaining 455.

1. Histories. Over 75 per cent of the histories were poor and incomplete. General history and physical examination were apparently hurriedly made with very little attention paid to details. Only two histories out of 455 cases delivered by the general practitioner carried notations of general pathology on the part of the mother.

2. Obstetric histories and labor records. The obstetric history like the general history was very incomplete and the labor record far from satisfactory. Time of examinations and results of examinations were only occasionally charted. Blood pressure readings, even in toxic cases, were not always recorded. Diagnosis of labor and notes on progress of labor were very incomplete. Indications for operative procedure usually were omitted from the chart. Results of operative deliveries only casually mentioned, such as "forceps attempted then a version done."

B. Patients. Eighty-four per cent of the patients were private cases. Primiparae outnumbered the multiparae 504 to 379.

C. Complications with results obtained. Complications were many and as might be expected rather bizarre. The complications occurring in this group of patients are not duplicated in the arrangement. For instance, an attempt at forceps followed by version will be considered as a version. Sixteen per cent of this group ended with an abnormality.

1. High forceps were used 15 times, 2 babies died. One operation was done by an intern at the request of a general practitioner. One consultation held after delivery of patient for repair of perineum. Two mothers were infected, but both recovered.

2. Medium forceps used 89 times; 9 babies died; 4 babies diagnosed as injured, possibly others. Seventeen mothers showed infection; temperature 101° or above for two days; all recovered. No consultations.

3. Breech deliveries occurred 33 times, 3 babies dead, 1 diagnosed dead before delivery; 1 mother infected, recovered; 2 consultations, mother and baby normal in each case.

4. Version with extraction was performed 26 times; 2 mothers died from shock and hemorrhage; 1 mother sustained a ruptured uterus. After the use of pituitrin, then unsuccessful forceps, version was done, baby dead. Consultation called; mother recovered, at least, sufficiently to leave the hospital alive. One mother of this group was infected, but recovered. The degree of lacerations which these mothers received was not recorded with sufficient accuracy to quote for statistical purpose. There were two third degree lacerations. Twelve babies out of 26 were dead; 1 injured, a 50 per cent mortality rate; 4 consultations were held, these mothers and babies had normal convalescence.

5. Cesarean section was performed 18 times, 1 patient in 49; 6 of these patients had obstetric consultation and were justifiable sections. The other 12 were handled by general practitioners and general surgeons. Four mothers were infected. Two babies died, their mothers having had one-fourth of a grain of morphine just before operation. There were no maternal deaths in this group. One vaginal cesarean section was done on an eclamptic by a surgeon and general practitioner; unable to deliver by forceps, a version was done. The baby was born dead and the mother died two hours later.

6. Preeclamptics were 12 in number with 7 dead babies, 1 mother infected but recovered.

7. Hemorrhage probably occurred more frequently than was noted in the history. One case which should be brought to our attention was a staff case handled by interns without supervision of staff physicians. Multipara with slow labor. Nose packed with ½ c.c. doses of pituitrin, resulted in severe postpartum hemorrhage; both mother and baby lived.

8. Mutilating operation on the child occurred 7 times; 4 mothers were infected making very slow recovery. One mother died after having had pituitrin, then an attempt at forceps, then an attempt at version, then forceps again. General surgeon called in consultation who did a decapitation, then a version, then pubiotomy, mother dying in twelve hours. Five consultations in this group.

9. Labor was induced several times without consultation. Once in a case of twins, weighing four pounds and eight ounces and four pounds and ten ounces respectively; both babies died. Another case of marginal placenta previa, manual dilatation, version and extraction, mother and baby dying. This case was counted under the accidents of

version. In a third case, the physician, a general practitioner, inserted a bag to induce labor. The baby's head was delivered before the bag, baby dead.

D. Normal deliveries in which complications developed.

1. Death of mother occurred in one case due to pelvic phlebitis and abscess, six weeks postpartum.

2. Forty-five mothers had infections from which they recovered sufficiently to leave the hospital, classified "improved."

3. Two babies died shortly after birth, no cause given.

4. Five babies were diagnosed as injured. There were probably more.

5. Many cases which were apparently normal but not progressing with sufficient rapidity were given small doses, two or three minims, of pituitrin. Twenty patients received ½ c.c. doses of pituitrin and in a few cases this was repeated several times. In this group of 20 cases, there were 7 stillborn babies. Such a shocking fetal mortality must be prevented.

E. Consultations with obstetricians were few, only 24 out of the 455 cases delivered by general practitioners. But in these cases very satisfactory results were obtained.

F. Interns. The interns handled the few staff cases in a very creditable manner, showing that they had been taught good obstetrics. Characteristic of inexperience, they attempted the spectacular at times, but in this they were aping the work of a few general practitioners. In general, the intern was not advised on the details of antepartum and postpartum care, nor the relation of complications, even minor ones, to the psychology of the patient. Scant attention was paid to the nursery, or to a study of the cause in cases of difficult feeding. Interns in general seem to feel that the problems of the baby are a nurse's duty. The members of the obstetric staff as a whole were careless and inconsiderate of the training of the intern in such details as taking him on rounds to see the private patients, and having the intern scrub for normal or abnormal cases.

In presenting the results of this analysis of cases, the intention is not to be hypercritical of the practice of obstetrics in any one locality, but to call attention to the state of affairs which I believe exists in general in the majority of hospitals throughout the country. Two conditions must strike anyone in looking over this group of abnormalities and their management. *First*, As to the helpless young intern in such surroundings, can we expect him to build up an obstetric conscience? *Secondly*, Can we admit that these patients have been treated in the scientific manner, which they had every right to expect as they entered their hospital, when such results are recorded as are here enumerated?

of the mother which might suddenly take her life, (k) repeated doses of pituitrin, (l) postpartum infection with temperature reaching 101° or above twice in forty-eight hours.

D. The superintendent of the hospital is to be notified as soon as a diagnosis of abnormal labor has been made.

E. That consultation shall be the rule of these hospitals in all cases of abnormality.

F. Consultants should be physicians of recognized obstetric ability and sound judgment, selected to the satisfaction of the staff, the superintendent, and the Board of Trustees. Rare is the patient, knowing that she has an abnormal labor, who will object to a consultation, either for personal or financial reasons. If the rule applied in all abnormal cases, physicians can raise very little objection to interference with their practice. If the matter of fees should arise as a barrier to this plan there are a sufficient number of good obstetricians in each community who will offer their services as consultant free of charge for six months or one year while the plan is being tried out.

G. Interns would receive training in the physical examinations of pregnant patients. A written commitment to diagnosis would sharpen their powers of observation and their ability in diagnosis. Knowing that his work would be supervised, the intern would be stimulated to better obstetric skill rather than a development in the art of bluffing. As assistant in all cases he would observe and be taught better obstetrics. If required to make rounds for private and staff cases, he would absorb many of the little details of postpartum care which have to be learned when he enters practice, often associated with unpleasant memories for both mother and doctor.

VII. CONCLUSION

After reviewing the obstetric work as it is conducted in three accredited hospitals this plan to better the obstetric situation in general is presented in a spirit of constructive criticism. The hope to safeguard the mother and baby at the time of delivery, and to place around the intern on obstetric service a more wholesome atmosphere, should be our aim. It is not the normal case handled properly nor the abnormal case handled intelligently which keeps our mortality rate so high. It is meddlesome obstetrics on the normal case and ignorant handling of the abnormal case which cause this needless waste of life.

In trying out these suggestions it is safe to assume that: (1) there will be no increase in our mortality rate, (2) the teaching of interns will be improved, and (3) as patients realize the protection and benefits they are to receive by this plan there will be more patients going to the hospitals for confinement.

You may ask, is not this plan an unfair encroachment in the field of the general practitioner? My answer, the only reasonable answer is:

"The principle, namely, to save the lives of mothers and babies, is far more important than the injured pride of any physician or group of physicians." Is not the aim and ideal of medicine to save human lives? I have enough faith in the general practitioner to feel certain that if the plan is given a fair presentation and trial that he will cooperate most enthusiastically.

If the practice of obstetrics in accredited hospitals could be standardized by this, or a similar plan, and be given the endorsement of a strong national organization backed by the American Medical Association and the American Hospital Association, a sudden check would be placed on the practice of meddlesome and ignorant obstetrics in our hospitals. Rightfully and logically the organization to further such a movement is the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons.

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