The Changing Practice of Obstetrics

William Benbow Thompson

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The date was May 9, 1922. M. D., age 25, para i gravida ii, had registered as an obstetrical patient the previous September 12th and was some 18 days beyond her estimated date of confinement when she notified me that contractions had begun at 6:00 a.m. Since she lived only a couple of blocks from the hospital, she was seen at home at about 9:30 and brought in for observation. Labor progressed rapidly and normally, and dilatation was complete at 11:30 a.m. No sedation or other medication had been administered. The membranes were ruptured artificially, and the patient was taken to the delivery room that had been improvised from one of the smaller operating rooms. Drop ether was given with contractions until the head began crowning when it was deepened to a semi-surgical degree. Delivery was accomplished spontaneously without episiotomy. A 1st degree laceration was repaired, the placenta was expressed, 1 cc of Pituitrin was given intramuscularly, and the patient was removed to her room, there to remain for two weeks, although she was allowed to sit up in bed on the 8th day, and out of bed on the 11th. The baby boy weighed 8 pounds 5 ounces, was breast fed, and progressed satisfactorily. The Obstetrical Department of the Henry Ford Hospital was officially opened.

I have given this somewhat detailed account of the first delivery within these walls partly because it has some historical significance on this occasion, but more particularly because it provides a basis on which to discuss the changes in obstetrical practice that I have observed in the past thirty-five years. At first glance, one might be pardoned for assuming that no great differences exist between the care of our first delivery and present-day patients. Certainly there are those today who extoll the virtues of “Natural Childbirth” and withhold analgesia and anesthesia. However, no one can deny that great and basic alterations have taken place which have entirely revised obstetrical thinking and practice. Without any idea of discussing all of these — to do so would require a text-book-sized volume — let us take up some of the significant developments that we older practitioners have observed. Let me state at this point that the order in which these are mentioned may not be at all in order of importance.

**OPERATIVE TECHNIQUE**

Among the chief advances must be listed the improvement in operative technique. Cesarean mortalities in the early twenties were grim indeed. Not only was there extreme danger of infection if labor had been established for any appreciable length of time, but subsequent pregnancies carried grave danger of rupture of the uterine scar, and sterilization usually was advised at the time of the second section. The net result, of course, was that Cesarean was avoided except as a last resort in impossible situations. Hence pubiotomy, a mode of enlarging pelvic diameters that I trust I never will see again; the Walcher position, guaranteed to establish permanent and intractable
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lumbo-sacral distress; version for cephalopelvic disproportion, in the hope that the after-coming head could be jammed forcibly into the pelvis when it would not enter under uterine contractions; and other procedures that were designed wholly to avoid the hazards of abdominal delivery. Especially to DeLee and Beck must be given credit for setting forth the merits of low-flap Cesareans. At least a moderate trial of labor did not increase the risks involved if Cesarean were finally employed, and the resultant scar was better suited to resist strain in subsequent pregnancies. By the close of the twenties, in the larger centers of population the newer operation was being done by the majority of obstetricians. Later, in the thirties, came the supravesical approach devised at the Hague, so that even neglected and infected parturients could be delivered without too great an increase in mortality. Logically, since operative attentions were made more safe than before, more patients were subjected to Cesarean rather than to brutal vaginal delivery.

One might remark in passing that the improvement in technical phases has not been entirely a net gain. As the tendency increased toward solving all obstetrical difficulties by Cesarean, alternative procedures have been practically abandoned. A whole generation of obstetricians have, for the most part, little experience in the modes of correcting malpositions or the performance of versions. Even breech position is listed as ample excuse for surgical delivery, particularly in primigravidae. The reason for this attitude is quite obvious. At Cesarean, the resident can see clearly the steps of the operation, and when he has his turn at being the operator, his errors are easily corrected. In intrauterine manipulations, however, teaching must be entirely didactic. One can only explain the need for gentleness in handling the babe during version, the accuracy with which forceps are adjusted in mid-pelvic arrest, but the resident cannot observe directly what is being told to him, nor can his own efforts come under scrutiny. Since his training has been better in abdominal delivery than in the more complex vaginal procedures, it is natural and proper for him to solve problems in the manner by which he can best serve his patients. However, in view of the excellence of results attained, I cannot align myself with some of my generation who decry loudly the broadening of the indications for section.

There is a further reliance upon better operative healing that I personally abhor. This involves the assumption that if convalescence has been without fever, uterine tissues are firmly reunited and capable of withstanding the forces of labor in later pregnancies. Hence, if the original indication for Cesarean was not a recurring one, the attendant might feel justified in attempting a so-called “normal delivery”. Such reasoning seems to me to be entirely fallacious. If any of those who have reported series of vaginal deliveries following Cesarean have discovered a means of diagnosing accurately the strength of the scar, I have failed to note it. Certainly each report has had a small percentage of failures, with uterine rupture, loss of the baby or uterus or both. Even maternal deaths have been occasioned by this over-anxiety to reduce Cesarean incidence. Moreover, the safe-guards that are advocated are prohibitive in cost, meaning cost in money. To maintain an operation room with nurses and anesthetist in constant readiness is simply too expensive. Even if the hospital is an endowed charitable institution, expenses still have to be paid with money, and in such instances I believe the money could be better utilized. Why chance disaster when a repeat section is even
safer than the original operation, and now presents no bar to the reproductive desires of the mother for additional offspring? At one of the hospitals where I work, and where repeat sections are almost invariably performed, we have not had a death after repeat Cesarean since the doors were opened more than 25 years ago.

One additional argument against vaginal delivery after Cesarean comes forcibly to mind. I live in an area known as a medico-legal hot-bed. Suits are filed with and without justification. Some years ago, our County Medical Association made up a panel of about 100 members with representatives of all specialties and of general practice, and gave this to the Bar Association as men qualified to confer with plaintiffs' attorneys to aid them in weeding out nuisance suits. At the same time, panel members were instructed to go into court as expert witnesses in cases where the plaintiff had been wronged. I have been on this panel from its inception, and I am sure that my experience in helping to avoid legal actions has not been unique. I am terrified, however, when I contemplate what must be my opinion regarding the loss of a mother, her reproductive organs, or her child when she and her family have relied upon the advise of a physician who has advocated "normal" labor in spite of a Cesarean scar and has had a ruptured uterus in labor.

SEPSIS

From the time of Semmelweiss and Oliver Wendell Holmes, infection has been recognized as the dread killer of postpartum patients. Within my day this danger has lessened to a remarkable degree, but it must never be forgotten that women still die if infection is not prevented. First the chemicals and then the antibiotics have served to rescue many who otherwise would have been doomed. The fear of infection, however, should remain uppermost in the mind of every obstetrician. It is not safe to rely upon the efficacy of curative agents, and particularly it is not safe to ignore or by-pass preventive measures in blind reliance upon modern therapy. There is an ancient fable about an old-time doctor who, when treating a desperately sick patient, was asked if the medicine he had ordered would cure the disease. His answer was that it probably would not, "but it will throw her into fits, and I'm hell on fits". No drug is invariable hell on infection. Here above all, prevention is better than cure.

Better technical procedures already have been mentioned as reducing the incidence of Cesarean infections, but one finds that not always is the preferable technique employed. I have been consulted relative to Cesarean after long hours of ruptured membranes or after vaginal manipulations by those who unblushingly admitted that they intended to perform not an extra-peritoneal approach but a low-flap section, "and I'll load her up with penicillin". Such arguments and attitudes are simply intolerable. If one is not willing to keep abreast with the times in techniques as well as in general measures, then he should not accept obstetrical patients.

HEMORRHAGE

Hemorrhage has been, and is, one of the feared complications of the last trimester, labor, and the postpartum state. Regardless of the efficacy of transfusions, the availability of blood, and the accuracy of laboratory matching tests, the sight of undue
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quantities of blood terrifies me. Possibly some of my alarm stems from the fact that I remember when transfusion was not something to turn over to a junior interne, but was a real operation. The first one that I saw involved cutting down on the median artery of the donor and the median basilic vein of the recipient, and then hooking up the two with a paraffin-coated tubing until the donor fainted or the recipient had a nice pink color. Needless to say, there were but few of the students that found they needed $25.00 badly enough to serve as donors. Quite probably we order transfusions nowadays too readily, for such treatment is in itself not without hazard. My personal decision in this is determined by two factors. First, if I would order blood were the patient at the County Hospital, then I want it for my private patient. Second, I want enough to replace the estimated loss plus another pint. Furthermore, I want fresh blood. Unless one is alert, when one orders from the blood bank the technician will reach for the bottle that will be out-dated in a few days. Above all, however, I try to keep in mind a remark I first heard from Edith Potter, that the only ideal blood for a patient is her own.

Since hemorrhage remains one of the chief causes of maternal mortality, are there means by which its occurrence may be reduced? I think there are, if one anticipates and prepares for it in advance. Certain patients with certain complications are more prone to bleed excessively, and steps should be taken to speed up active therapy should one's fears be realized. Patients with real or suspected placenta previa or premature separation are obvious candidates, of course, and typing and cross-matching should be done immediately on admission. Others for whom this may be important are those with twins, hydramnios, long and tiring labors, or with a history of excessive bleeding at earlier deliveries. An hour or more is saved in the instituting of transfusion if preparations are already completed. This includes the placing of a large-bore needle and keeping it open with a slow drip of salt or glucose solution when the patient goes to the delivery or operating room. Thus the sudden dismay at finding veins collapsed and shrunken is avoided. In the face of extreme hemorrhage and falling blood pressure, every minute until adequate quantities of blood replace that being lost is of utmost importance. The saving of minutes here means the saving of lives.

TOXEMIAS

In no phase of therapy has there been more improvement than in the care of the toxemic patient. To name over the treatments of the past used to reduce blood pressure and the convulsive state that I have utilized or seen employed makes me realize that I am indeed aged if not altogether antique. Blood-letting in 18th century style I saw once as an interne, when the attendant in attempting to correct a pressure of around 250 mm. inserted a large needle into an arm vein. The stream that gushed out hit the opposite wall of the cubicle. Williams of Hopkins had already declaimed loudly against rapid and shocking emptying of the uterus during the height of the attack, pointing out that the reason for lower mortality in postpartum eclampsia was due to the fact that one could not then terminate the pregnancy by accouchment forcé. However, eclampsia was still the "disease of theories", of which one of the most popular was the hydrops gravidarum theory of Zangemeister. This was maintained by E. D. Plass, the first to head the department here. Empirical treatments, with or
without theoretical basis, were suggested in profusion. The Stroganoff regime, wherein morphine was given until the respirations dropped to 8 or 10 per minute; purges, sweats, and even control of convulsions with chloroform; these seem relics of a past age, as indeed they are. One of the first steps toward logical treatment was the use of intravenous magnesium sulphate, in that both sedation and lessening of blood pressures was accomplished. By this means the mortality of eclampsia at the Los Angeles County Hospital was reduced to less than half its previous level. Incidentally, it may be of interest that this treatment was suggested by an extremely intelligent interne, Dr. Emil Bogen, whose name was barely mentioned in the early reports published by the department chiefs of that time.

Researches of the last decade have been fruitful indeed. Dieckmann, Chesley, Page, and Assali, to name but four of the foremost investigators, have added much to our knowledge of this most perplexing condition. Apresoline and Unitensol are active drugs and have effectively aided clinical management. It must not be assumed, however, that one can now view the eclamptic patient with composure. Toxemias are better prevented than treated, and active care should begin long before the first convolution demands emergency care. Total results are improved to an encouraging degree, but the millenium is not yet at hand.

ANESTHESIA

It is somewhat paradoxical that anesthesia, in which so much improvement has been accomplished, should now rank as the Fourth Horseman, in that now it rates ahead of embolism as a cause of maternal death. Anesthetic deaths have not increased, of course. To the contrary, anesthetic agents are safer now than ever before. It is merely that other factors in maternal mortality have been reduced to a greater degree. Obstetrical anesthesia is far different in management than surgical attentions. Patients are not often seen at convenient times, or with empty stomachs. In the flurry of moving to the delivery room, an interne, resident, or nurse is pressed into service to administer what is potentially a lethal drug. All too few hospitals maintain a service providing competent anesthetists in the Obstetrical Department at all hours, and where this is attempted, all too often another delivery demands the anesthetist's attentions before the first patient is safely on her way to the ward. The result, of course, is chaos. The attendant, faced with the choice of no anesthesia, drop-ether by a nurse, or no anesthesia at all, often resorts to saddle-block spinal given hurriedly by himself, and then, without having time to see if the effects are all that could be desired, starts to scrub for delivery. It is hardly remarkable that there are some fatal drops in pressure or fatal reactions to the drugs employed.

I prefer conduction anesthesia to general. Given properly, and supervised properly, reactions should be few and far between. Caudal anesthesia seems preferable to me because it can be administered earlier, avoiding the last-minute rush that is so disturbing. I have no quarrel with pudendal block except that it does not alleviate fundal pain and is often given in a hit-or-miss fashion. The tragic thing to me is that a means of giving relief should ever be the cause of grief beyond endurance. Improvement of administration is the urgent problem in anesthesia.
If one looks through the “Year Books” from early in my professional life, he will find a considerable number of abstracts giving the results of series of prolonged labors. In these reports it was evident that lengthy labors meant a rising toll of mothers and infants, and the morbidity rates were high indeed. There were valid reasons for tests of endurance in those days. Low segment operations were just beginning to be advocated, and the hazards of the classical procedure after labor had dragged out for many hours were known to be greater than with further procrastination. “Watchful waiting” was one’s rule of conduct, even when one did not know for what he was watching and was merely waiting for disaster to descend upon him and his patient. Happily, those days are over. Present thinking is more concerned with the results of delivery than with the mode of its accomplishment. (One must expect the authorities of the Joint Committee on Accreditation who persists in holding as a tenet of faith that abdominal delivery rates must not exceed four percent regardless of the best interests of mothers or babies.) Hence many of our hospitals require consultation with one of the senior obstetricians if labor has not been productive within 18 to 24 hours. This, I believe, is sensible. Why wait until the mother’s resistance has become dangerously depleted and her baby battered into a depressed state before determining that prospects are becoming less favorable each hour? Pleas for earlier intervention are not a recent matter. As far back as 1887, Robert P. Harris of Philadelphia collected a series of 9 women who had been delivered at the horns of cattle, deer, and buffalo, and compared the results — 5 mothers and 5 infants survived — with Cesarean statistics from New York City and in the country at large. As Harris sagely remarked, the better percentages of the animal operators were aided by the fact that their deliveries were done upon patients “when in the full possession of their usual strength and health”. It took more than half a century for his warning to receive much recognition, but for the past 15 years or so there has been much less tendency to see just how much agony a woman in labor can endure and still survive. The avoidance of useless and dangerous delay, then, I would set forth as a change distinctly for the better in modern day practice.

It is customary in reviews of this type to remark at some length upon the improvement of prenatal care. I would like to do so here, but I am restrained by the fact that I am not sure as to just what constitutes good prenatal attentions. How does one define this? One of my younger conferees sees his patient every other day when they have reached 38 weeks. Another phones his girls every day at this stage of gestation. Either plan would bore me to distraction and must be a great nuisance to patients, but both of these men have sizable practices so it must be impressive. I am disturbed also by the lectures of our professors on this topic. Almost invariably, after dissertating at length upon the need for individualizing one’s advice, they then set forth a “routine” to prescribe iron whether the hemoglobin level be high or low. It is “routine” to utilize routines to avoid considering the individual need of the patient at hand. Someway I cannot subscribe to the belief that one’s excellence of prenatal care should be measured by the number of pills that one can force down the unprotesting gullets before him. If one must use a routine, let it be that he does the very best he can for the patient he is seeing at the moment.
One of the compensations of nearing the end of professional activity is that one can look back and reminisce. As I have tried to show, I have seen vast changes in what has been considered to be proper practice. Nor is the present status fixed or beyond improvement. Tomorrow may see many of our bright ideas outmoded. Some years ago I heard my good friend, Dr. Karl Schaupp of San Francisco talk to a group of medical students about his experiences in the Gold Rush of the Klondike. Karl had climbed Chilkoot Pass, gone through Skagway and down Whitehorse to the headwaters of the Yukon and richer diggings, although he failed to profit materially in their wealth. He made the hardships of weather and terrain stand stark and raw before us. Then he placed before us a comparison of his pioneering days with the lives of his young auditors. Physical frontiers were practically things of the past, he remarked, but in Medicine there were frontiers that were boundless, so that no man of medicine might ever feel himself restricted and hemmed in by lack of new territories to explore. If we be not among those that make the new discoveries, at least let us keep the leaders within our vision and not fall hopelessly behind in the march. Only by making changes is Progress accomplished.