THE YEAR BOOK *of* OBSTETRICS *and* GYNECOLOGY

(1962-1963 YEAR BOOK *Series)*

EDITED BY

J. P. GREENHILL

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YEAR BOOK MEDICAL PUBLISHERS

INCORPORATED

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THE PRACTICAL MEDICINE YEAR BOOKS

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PRESIDENTIAL AND OTHER ADDRESSES

Aldrich (Am. J. Obst. & Gynec. 82:961, 1961) chose as his presidential address before the American Gynecological Society, "Thomas Addis Emmet," who made significant contributions to the founding of modern gynecology and who by his precepts reduced some of the hazards of obstetrics as practiced in his day. For 5½ years, Emmet assisted Sims at all of his operations. He mastered the technic for closure of fistulas and it was not long before he was doing two thirds of all the operations performed at the Woman's Hospital, New York. Emmet's approach to surgery was analytical and methodical. He was inclined to adhere to surgical procedures which had proved themselves to be sound and efficient, but he did devise some improvements in the procedures which he had learned from Sims. At 33 years of age, Emmet became chief surgeon to the hospital. At considerable sacrifice, he gave up obstetrics and a lucrative general practice to devote all of his time and energy to his hospital duties. Emmet made many significant contributions to the development of obstetrics and gynecology. By 1900, he had operated on 600 vesicovaginal fistulas. In 1876, he read a paper on "Uterine Flexions" before the American Gynecological Society. It was actually the first paper presented at the first scientific meeting of this society. Emmet's approach to gynecologic problems was always a conservative one. He was opposed to vaginal hysterectomy for prolapse unless the patient had such uterine abnormalities as fibroids. He warned against indiscriminate removal of ovaries and, when possible, he resected ovaries for ovarian cysts. At 72 years of age, Emmet terminated his career in gynecology. He devoted 8 hours a day to reading and writing until his death at nearly 91 years of age.

Parks (Am. J. Obst. & Gynec. 83:841, 1962), in his presidential address before the American Association of Obstetricians and Gynecologists, selected as his subject "Privileged Communication." He said the physician who develops eyes that see, ears that hear, hands that feel and are hardly felt and a heart that joins his mind in concern for his patient will sense the deep satisfaction of the profession. All professions have a technical language modified to variable degrees by the vernacular, by slang and by an abundance of abbreviations. During the developmental period of our professional lives, slang and abbreviations too often become a superficial badge of professional identity. Of all forms of communication, abbreviations are the most confusing. [How right!] A distinct responsibility accompanies our title of "Doctor of Medicine." When we communicate with the public, we speak not only for ourselves but as representatives of a great medical tradition. We are judged by our personal behavior as well as by our professional ability. Although the public currently outnumbers physicians in a ratio of about 750 to 1, we can influence directly and for the better the lives of each of the nonmedical members of

our society. It is most important that physicians actively convey to the public appropriate information about modern medicine. The public is vitally interested in medical news, for health is man's most important possession. A great degree of self-discipline is required to keep inviolate all privileged information about our patients. While courts now provide some protection against public disclosure of confidential medical communications, a patient's privacy is best assured by the good judgment of the physician. Obstetricians and gynecologists have a tendency to use overlapping terminology. Expressions in obstetrics are not necessarily applicable to gynecologic patients. Many miscarriages of meaning between the patient and the physician are based on misinterpretations. The greatest art in medical practice is the ability to give undivided attention to the individual patient. Impatience on the part of the physician is quickly sensed. Attitudes and feelings are communicated without words. The physician who develops the ability to listen frequently finds the truth of his troubled patient's problem. Privileged communication is sometimes handicapped by the presence of other patients or professional personnel. Under such circumstances, the patient can be encouraged to write out questions about which she hesitates to speak. The physician can then answer verbally or in writing, as indicated by the questions asked.

Hodgkinson (Obst. & Gynec. 18:243, 1961), in his address before the American College of Obstetricians and Gynecologists, spoke on "Continuing Education in Gynecology-Obstetrics." Hodgkinson said the College not only has an inherent right but also an obligation to assert active interest in continuing gynecologic-obstetric education. It is pitiful that there is no official definition for the branch of medicine we call "gynecology-obstetrics" or "obstetrics-gynecology." He proposes the following definition: "Gynecology-obstetrics is that branch of medicine which deals with those biologic factors and functions of the human female which are immediately and remotely related to reproduction." He points out that in contemporary medical education three decisive eras can be identified with eponyms. The first, the "Osler Era," is synonymous with the residency system of medicine developed at the Johns Hopkins Medical School; the second, the "Flexner Era," was identified with the report by Flexner in 1910 as a consequence of which an abrupt end was put to preceptorship training and to the diploma-mills-for-profit medical schools. Teaching was to be done by teachers in facilities devised for teaching; the third, the "Commission Era," developed much less conspicuously. It was the result of a study by the commission of medical education sponsored by the American Medical Association, the final report of which was published in 1932. From this study came the realization that medical schools could no longer teach every facet of every subject. The Commission recommended that medical schools concentrate on teaching the principles of medicine and general sciences which were likely to remain the basis of medical practice, research and teaching. Hodgkinson believes we are now in a fourth era of medical education and that it has resulted from the impractical application of the ideals of the "Osler Era," the "Flexner Era" and the "Commission Era" to a changed society. Unforeseen and unanticipated were "population

explosion," "science explosion," "social welfare explosion" and "residency explosion." Now the cry is too few good students, too few patients for teaching, too few teaching hospitals, too few teachers and too much research by teachers who should be teaching. Thus the "monster" of the Flexner report—teaching by nonteachers—is back.

Hodgkinson thinks that the first act of the College should be to sponsor a meeting of medical educators, hospital administrators, directors of residency programs in nonteaching hospitals and representatives of the College. The agenda for this meeting should include three major topics: (1) the means for making the directors of the nonteaching residency programs an integral part of teaching education, (2) the development of educational aids for the resident in training and (3) the contributions the hospital administrator can make in providing proper experimental laboratory facilities for training in surgical technic.

Hodgkinson also emphasizes the supporting role of the College in working with other professional groups, particularly with respect to organized nursing. He believes that the College should boldly show its allegiance to organized nursing and actively support the concept that the fundamental unit of medical care today is, as it has always been, the doctor-nurse team. This kind of loyalty is a debt the College owes to the dignity of medicine.

The title of Israel's presidential address before the American Society for the Study of Sterility (Fertil. & Steril. 12:397, 1961) was "Yang and Yin—The Antipodal Complements of Fertility." His theme was devoted to defending the dual character of the annual program of this Society and to denigrating the single-tracked antipathy of some of the members to it. The schizophrenic attitude of these few, demanding on the one hand a policy stressing purely clinical reports and on the other urging emphasis on wholly scientific abstractions, is to be deplored. It is Israel's thesis that continuing education in the processes of human fertility is the most basic need and the most important responsibility of the Society. This double function is lost without literate communication between the investigator in the laboratory and the clinician experimenting in office or clinic. The two disciplines coexist because of and for each other, their interplay serving both to probe weak spots and to bolster the strong in each other. Since they are different, each seeming to exist for its own sake, it may have seemed logical at one time to keep them far apart. But one can no more separate the ultimate objective of the carefully controlled basic science of fertility from that of the often empiric treatment of the infertile couple than one can separate time and space. Israel urged the Society to continue to keep itself the mixture that it is, striving to maintain a logical order in its effort to close the gap between the forefront of growing knowledge and the infertile couple. We must continue to decry the separateness of two self-centered disciplines—laboratory research and clinical investigation. There is no room for such a dichotomy. The investigators of basic science digging in the unknown and the careful clinical observer probing for practical applications to the world of patients must continue to facilitate their exchange of ideas. Fences should be torn down, not erected.

DeCosta (Am. J. Obst. & Gynec. 83:1121, 1962), in his presidential address before the Central Association of Obstetricians and Gynecologists, spoke on "Care and Feeding of the Young Physician." He said that in the young people we have a resource of great value if we will only utilize it. He refers to those who are still in training either in the medical school, in the hospital or in the faculty. Chronologically, this represents an age group between 20 and 35. To improve training, we must provide the best and most experienced teachers, the most efficient and complete physical facilities and excellent material to work with. The first is probably the most important because the good teacher not only imparts knowledge but also inspires and stimulates the student to greater effort. A teacher should *like* people and *like to teach.* He should possess the necessary intellectual capacity, stay abreast of his field and be articulate. He should also have time to teach and to prepare for his class. With all these positive assets, a teacher can still be deadly unless he possesses that spark which excites and stimulates the curiosity of his pupils. Fortunate indeed is the young man who has had a chance to work under an interested and inspiring teacher. The young men and women who have completed specialty training may need our help and guidance more than ever. They have several simple but important needs. They must have financial security, be encouraged to follow their interests, be given material with which to work and have an incentive—yet not be spread too thin. This applies to those in full-time positions as well as those in private practice. Proper utilization of talent obviously involves the older man as well. It is he who should shoulder the heaviest teaching load because it is he who is most experienced and most respected. Usually, however, the higher the rank the less the teaching. All too often the heaviest schedule is assigned to the youngest and least experienced faculty member. DeCosta thinks this is wrong. The older men should not be put to pasture. There are two things we must not do—to ask a young man to teach, to run a clinic, to handle a ward, to do research and to write may be just sufficient to scare him away or to reduce him from great potential accomplishment to mediocrity. The second thing is never to discourage him. It seems to be a human trait to resist change, and particularly new ideas. In summary, DeCosta pleads for greater attention to the younger man, whether he be a student, a member of the house staff or on the faculty.

Louros (Am. J. Obst. & Gynec. 83:1189, 1962), in his Guest Speakers' Address before the Central Association of Obstetricians and Gynecologists, discussed "The Concept of Radicality in Gynecologic Cancer Surgery." He asked, "What do we really mean when we speak of radicality?" It is generally believed to mean the removal of the uterus and its appendages with the main part of the parametrial tissue and the lymph glands and lymphatics therein contained. This definition is, however, not accurate enough for comparison of results. Extensive radicality either by dissection or by the pulling and tearing technic (which in Louros' opinion prevents blood loss owing to the contraction of the small vessels and capillaries) and even by exenteration does not create an increased threat of metastasis. Statistical data show that the incidence has no connection with extensive practical

procedures, for this extensive radicality leads definitely to better end results. Louros says that our statistics do not allow satisfactory and understanding comparisons. The classification, registration and the setup of our cases involve so many mistakes and fallacies that a comparison of similar cases and of equivalent operative procedures is hardly obtainable. Most confusing is the interference of irradiation which depends on clinical and pathologic aspects, source of irradiation and radiosensitivity as well as on the fact that staging of irradiated and nonoperated cases is susceptible to a high percentage of mistakes. Little consideration is given to the residual presence of cancer tissue in the parametrium when it is found at operation shortly after irradiation. Surgeons differ in clinical acumen and operative skill. Even the same surgeon may operate more or less radically on one or another day.

For all these reasons, Louros raises the question of the concept of radicality to which he dares not give a definitive answer.

Hesseltine's (J.A.M.A. 177:899, 1961) title of his presidential address before the Section of Obstetrics and Gynecology of the American Medical Association was "Does Change Imply Betterness?" He said that apparently it does when it is weighed, balanced and developed in a mature sense, carried through with scientific skill, not to prove a point but to learn one. Change implies betterness when it is dynamic but conforms to the practices of society. If progress is to take place, change is inescapable. Betterness may follow, provided these alterations are made soundly, logically and precisely. Open-mindedness for modification periodically after critical appraisals and re-evaluations determines real viability. Therefore, change can imply great betterness but does not assure it. Betterness, like liberty, must be continually and faithfully guarded.

Judd (Am. J. Obst. & Gynec. 81:1073, 1961), in his presidential address before the Pacific Coast Obstetrical and Gynecological Society, chose as his subject "In the Pursuit of Excellence." He said that during the past 5 years he had had the opportunity to review a significant number of cases involving litigation arising out of obstetric and gynecologic care. The information regarding these cases was developed by a trained investigator who painstakingly interviewed all personnel involved—doctors, nurses, attendants, patients and families. The total scope of his experience involved about 500 cases, of which 51 concerned obstetrics and gynecology. There are certain observations that seem worthy of discussion based on a thoughtful analysis of these reports. It is reasonable to assume that the ultimate degree of patient dissatisfaction is represented by the filing of a suit. About 40% of the cases seemed to point to physician failure not in technical skill or ability but rather in failure of the doctor in his personal relationship with his patients or the family. Significantly, the Board-certified doctor was involved about half the time. The possible provocative motives were summarized after a critical review of all the information, and a partial list of these complaints follows: (1) lack of candor in explanation of complications, (2) lack of concern for patient's feelings or welfare, (3) "flippancy" and poor taste regarding personal problems of patients, (4) delay in imparting impor-

tant information, (5) anger instead of logical explanation, (6) impetuosity, (7) arrogance and (8) lack of serious attitude toward major problems of the patient. Judd stated that recognition of what we do in our personal relations with patients is as important as what we do with our technical skill and knowledge is vital for the best of the art and science in the practice of obstetrics and gynecology.

Hellman (Am. J. Obst. & Gynec. 83:503, 1962), in his presidential address before the Brooklyn Gynecological Society, spoke about "Paraobstetric Personnel." In 1959, there were over 4 million births, with but a few more than 5,000 diplomates, and only a fraction of the total labors could have been conducted by Board men. That we obstetricians in the face of this load are not now doing quite as good a job as we formerly did is discernible on close scrutiny of current statistics, for there is a small increase in perinatal mortality not only in Brooklyn but in the country at large. We must look to our obstetric man-power resources if we are to care for the predicted 5 million births in 1965 and 6.8 million in 1975—yet more obstetricians are not in the predictable future. One of the most logical solutions is that of expanding the efficacy of the physician by the use of paramedical personnel who are not physicians nor must they possess the resources to become physicians as we now know them. They are less broadly and extensively trained individuals who have pinpointed instructions to perform a specific task which they can do very effectively. In obstetrics, the most obvious paramedical personnel is the nurse-midwife. A graduate nurse specifically trained in the mechanism of normal labor and delivery, with knowledge and alertness for the abnormal, can extend the hand of the obstetrician immeasurably. With such a person following patients prenatally and in labor, the practitioner could double his activities with no loss of personalized or meticulous care of his patients. Nurse-midwives, properly trained and under supervision of the few paid full-time obstetricians, might satisfactorily staff the maternity services of some of our nonteaching government hospitals. At the King's County Hospital, Hellman in cooperation with the Maternity Center Association is contributing to the development of such personnel. Under the supervision of the State University of New York, 3 assistant professors of obstetric nursing have been appointed. They are able young women, nurses with graduate degrees and certificates and experience in nurse-midwifery. They have immediate supervision of the nurse-midwifery students. The practical work of these students consists of total obstetric and nursing care, including delivery. In a year's operation, 345 labors and deliveries were conducted under this program. Other institutions have similar programs but the author's activity is unique in that it is the first in the United States to be established in a municipal institution. Hellman hopes that the American College of Obstetricians and Gynecologists will take cognizance of these activities to inspect their content and their worth so that in the future they can issue a certificate with the added significant line "Certified Nurse Obstetrical Assistant A.C.O.G."

Shirodkar (J. Obst. & Gynaec. India 12:143, 1962) delivered the fifth Sir Kedarnath Das oration and chose as his subject "Tuboplasty."

He began by saying, "Greenhill and Hellman in the United States set this ball of pessimism rolling a few years back by collecting statistics of the results of tuboplasty from a number of operators in the United States and elsewhere. If one looks at this report, it is evident that the various operators mentioned had had hardly any experience in tuboplasty. They had done anything from two to twenty cases in their entire career." May I call Shirodkar's attention to the fact that I specifically said the following: "I reviewed the world literature for all reports where *ten* or more operations had been done." Certainly no one in the world can match Shirodkar in his experience with tuboplasty, because he says "I do two to ten tuboplasties each month."

Shirodkar discusses in great detail his technic for the different types of operations he performs. He assesses his results as follows: Grade I —(a) where an occlusion is only at the cornua on one or both sides not extending beyond the first two inches of the tube. Pregnancy followed in 40%. (b) same as above but with fibroids, the removal of which leaves the uterus in good condition. The success rate was 30%. Grade II—besides the bilateral cornual block, as in Grade I, the fimbriated ends are adherent but can be opened and look normal when adhesions are separated by salpingolysis. In these cases, there was a 20% pregnancy rate. Grade III—same as above but one of the tubes is rendered completely useless by adhesions or a large hydrosalpinx. This yielded 15% pregnancy. Grade IV—bilateral cornual block with fimbriated ends sealed and with or without small hydrosalpinx. This yielded no pregnancies. Grade V—bilateral cornual block with good outer half of the tube but with associated endometriosis or chocolate cysts with or without visible adenomyosis. This gave no pregnancies. I wonder whether the statistics given for these 5 grades of operation performed by the gynecologist with the largest experience in this field constitutes optimism for tuboplastic operations. Incidentally, Shirodkar lists 6 complications which may follow uterotubal implantation. He is still trying to see why his technic cannot be improved to yield a higher percentage of success.

Yagi (J. Obst. & Gynaec., India 12-311, 1962) delivered the Dr. Dossibai J. R. Dadabhoy Bombay Obstetric and Gynecologic Society Silver Jubilee Oration. He discussed the Okabayashi operation for carcinoma of the cervix which is now called the Japanese technic of radical operation for carcinoma of the cervix. This operation was first reported in 1921 and a modification in 1928. By the end of 1961, about 2,700 of these operations had been performed, chiefly for stages I and II but also sometimes for stage III. About 2,500 patients were also treated by radiation. Decision as to choice of operation or radiation was made by the patient and her family. The Okabayashi operation consists of extensive abdominal hysterectomy and complete pelvic lymphadenectomy. It is radical because (1) the resection of the cardinal ligaments is more extensive than in the Wertheim operation, (2) resection of the vesicouterine ligaments is extensive and complete and (3) removal of the pelvic lymph nodes is complete. The cure rate for stages I and II was better in Japan than in the International Report. In Japan, 79% were cured in stage I and 54.4% in stage II, while in the Stockholm report 70% were cured in stage I and

48.6% in stage II. Pelvic nodes were positive in 12% for stage I, 23.7% for stage II and 50% for stage III.

Douglas Miller (J. Obst. & Gynaec. Brit. Commonwealth 69:142, 1962) delivered the first James Young Simpson oration. He pointed out that all the evidence of contemporary writing and of biographic notes indicates that Simpson must be ranked as one of the greatest teachers in the history of obstetrics. The qualifications that Osler demanded in a good teacher—the ability to bring an atmosphere of enthusiasm into the classroom, a full and personal knowledge of the subject and a sense of obligation which impelled him to be also a contributor—these attributes were his in full measure, and in a few years the class of midwifery became, for the first time in its history, the largest in Edinburgh University, attended daily not only by students but by graduates from all over the world. The discovery of the anesthetic property of chloroform is, of course, Simpson's chief claim to the grateful remembrance of posterity. Simpson used ether 3 months after Morton's demonstration in the first case of midwifery in which a general anesthetic was ever employed. Two months later, he published a series of cases in which ether had been used with success. Shortly after this, Simpson tried out the use of chloroform. The story of Simpson's fight for anesthesia cannot be read without admiration for the courage, the single-mindedness and the personal force which enabled him to challenge, defy and overcome the forces of ignorance, prejudice, casuistry and obscurantism by which he was opposed. He produced statistics to show that the mortality and morbidity of surgery, far from being increased by anesthesia, were reduced by the elimination of shock and of the necessity for speed. It was not until Queen Victoria had been given chloroform in her confinement and had pronounced favorably on it that the fight for anesthesia was won. Chloroform anesthesia led to a complete change of attitude toward the management of delayed labor and resulted in an enormous saving of maternal and fetal life. Puerperal sepsis and the monstrous toll of life it exacted inevitably attracted Simpson's attention. His studies on infection, both puerperal and surgical, directed his further thoughts to the part which hospital design and organization might play in its incidence and transmission. He was convinced that overcrowding and inadequate ventilation of hospital wards were important agencies.

Three qualities emerge from an analysis of Simpson. First was an intellect exceptional in its discernment and resource and balanced versatility. Simpson was essentially a man of action, not a philosopher; a realist, not a theorist. He was a master of obstetric strategy and at the same time a brilliant exponent of tactics and technic. A second factor in Simpson's success was a dynamic personality of which the chief components were an exuberant vitality and an ardent enthusiasm, together with great goodness of heart. A robust individuality formed another facet of his character. Nothing was accepted that he did not first prove for himself. The third factor, and perhaps the most important, was his prodigious industry. Year after year, despite the increasing demands of other work, his literary output continued to be enormous.