EVOLUTION IN OBSTETRICS AS FAR AS IT RELATES TO EASTERN INDIA

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In this article I have included the area and the jurisdiction of what was demarcated as the Bengal Presidency in Government records in the early part of the present century, to represent Eastern India. While going through Gazetteers and other blue books published by Government, I found certain interesting references in connection with civil court judgments about inheritance, adoption, etc. and criminal court judgments in connection with infanticide, which throw some light on the status of obstetrics during the later part of the nineteenth and the early part of the present century. The facts gathered from my personal experience are from actual instances in the present States of Uttar Pradesh, Bihar, West Bengal, Assam, Orissa and East Pakistan.

The task of tracing the Evolution in Obstetrics becomes difficult because the lack of recorded information on treatises or publications from local sources in this part of the country. The systematic care of the expectant mother by a medical practitioner trained in any system—Ayurvedic, Allopathic, Homoeopathic or Unani, and by members of either sex was never practised as a routine. This would not mean, however, that the expectant mother got no antenatal care. A very meticulous and elaborate social and quasi-religious ritual was routinely gone through directly it was discovered that a daughter or a daughter-in-law of the house was "enciente". All classes, rich and poor, followed the same identical ceremonies and performances. The economical circumstances of the persons concerned determined the simplicity or grandeur of the ceremonial items, but the essentials were the same in all classes of society. The religions, professed, determined the varieties of the ceremonies. Even amongst some of the Adivasis, for example the Mundas and Oraons of the Chotanagpur areas, who do not profess any coded religious faith, there was an elaborate system of the ceremonies to be gone through by the expectant mother periodically during the months of gestation.

I had the fortune of hearing from the late Sir Kedar Nath Das and the late Dr. Sundari Mohan Das the modern explanation of some of these ceremonial performances. The so-called physiological vomiting of early pregnancy was treated by an elaborate dietary for the patient. Articles of food as would appeal to the patient were requisitioned and the food had to be taken during particular hours of the day and served by special persons. The psychological aspect of the mother received attention. She was

kept in congenial surroundings in association with veteran mothers. Excessive joy for the expected motherhood and undue fear for the apprehended ordeal, viz. labour, were equally discouraged.

With the advent of the Europeans, antenatal care of some sort was conducted in the houses of the rich and the opulent by nurses trained in European countries or by indigenous persons trained by foreigners. Some Government records and accounts mentioned in personal diaries of the rich show that French and Irish midwives were popular in these rich houses. These ladies very often extended their good services to the houses of the poor of the locality. The usual practice was to employ these ladies as companions to the expecting mothers from the very early months of pregnancy. Most of these foreign-trained midwives gave a good account of themselves and had enviable reputation, so much so that their services were requisitioned throughout the length and breadth of the country. The feudatory chiefs, the so-called native princes, were related to each other by marriage. It was a common event for a princess from Rajputana to marry a "His Highness" in Orissa. A midwife who looked after the mother was recommended for the daughter. The midwife used to travel with her retinue which consisted of, amongst others, one or two prospective "wet nurses" and some assistants. As the process of giving birth to the baby was looked upon as an unclean business, the relations would not go near the place or touch the girl in labour, the assistants were usually women of the "untouchable caste". Their profession subsequently became hereditary, the daughter taking the mother's job. This would seem to be the origin of the "Chamain" dhais of Northern India and the Barber women of South India.

The Christian missionaries, as is well-known, have done remarkable good work in this line. Due to various reasons the death of women at child-birth was much too frequent. To prevent this the Christian missionaries set up hospitals in various parts of the country even in remote small towns. In these hospitals, country midwives were trained. These persons were not expensive to employ and though very few in number did substantial good work in minimising the number of deaths and accidents of labour.

Towards the beginning of this century, throughout the country, ideas for preventing diseases and epidemics, and common causes of waste of human lives began to permeate through the medical and health departments. The enormous number of deaths and accidents at the time of child-birth naturally attracted the attention of the authorities. Antenatal care as an essential step for the prevention of the aforesaid calamity was adopted slowly and gradually through the medium of Hospitals, Outpatient Clinics and later, through the well-organized institutions meant for maternal and child-welfare. About forty years from now this work was stimulated when the teaching centres took upon themselves the responsibility of providing more elaborate training in Obstetrics for the future medical practitioners. This sequence of events took place throughout our country. This step

was taken by the Government of India under the British rule.

The practice of obstetrics slowly and gradually passed into the hands of medical practitioners even though the bulk of confinements were undertaken by midwives. Difficult cases were frequently badly handled as they are still being done by the midwives, badly trained or not trained at all. The female members of the medical profession had practically the monopoly of this practice. Eastern India, however, followed the lead given by Western and Southern India where men-widwives gradually appeared on the scene. Even now the men doctors are infrequently called in for normal confinements. In this part of the country they are called in more frequently for abnormal cases than for the normal ones.

Institutional confinements, which are so popular after the last war and particularly after the partition of the country, were few and far between even as late as 1930. When new Medical Colleges were established in Lucknow, Patna, Nagpur, Cuttack and even in Waltair, the students did not get enough cases for study and practice. In consequence they were sent to hospitals in Southern India where hospital confinements had become popular earlier. In most of these places there were institutions staffed by well-trained women doctors. Even with all that, in normal cases people desired to be confined in their own home surroundings. There is almost a social custom for the expecting mother to have her confinement in the familiar surroundings of her parents' household.

With the growth of a number of hospitals and institutions staffed by well-qualified nurses and doctors of either sex and perhaps with a deterioration of economic conditions and consequent dearth of housing facilities, institutional confinements have increased so rapidly that it has become a very critical and difficult problem for administrators to make adequate arrangement to meet this justifiable demand in a welfare state as is ours. In a big hospital under Government control in Calcutta, the number of confinements in 1928 was 999. In the same institution the figure in the years from 1952 to 1959 have averaged between twelve to fourteen thousand, the population have, in the meantime, increased about ten to twelve times.

Of the accidents in obstetrics many interesting accounts are on record. In the villages where the majority of the people live, scientific obstetrics as we now understand did not exist. The commonest fatalities took place in abnormal confinements. Sepsis claimed about two-thirds and haemorrhages about the remaining third of the deaths. Another pitiable sequel of obstetrics was and still is what may be called 'living deaths' where women mostly between the age limits of 14 to 20 suffered from huge fistulae, vesico-vaginal, recto-vaginal or both in the same person. Osteomalacia used to be very common amongst women behind the purdah. Forty or fifty years ago doctors, usually men, attached to Government, District Board or Missionary Hospitals in Sub-Divisional or Thana centres, were frequently called upon to perform destructive obstetrical operations, viz. craniotomy, decapitations and evisceration. I have seen as late as 1935-40 in some hospital theatres

the instruments required for these operations which were the only 'Midwifery Instruments' in the operation theatre cupboard. The plane 'Midwifery Forceps' was conspicuous by its absence.

It is a great pleasure to record and to note with a teacher's pride that such accidents and instances of 'living deaths' are definitely on the wane. In a big institution where I have worked for 45 years without a break, as a junior member of the House Staff I looked forward to have at least six cases of destructive operation to be conducted by myself during the period of six months. As a contrast to this state of affairs I may state that during the last year of my services as the chief of the same institution I recorded only three cases of decapitation and only one of craniotomy amongst a total number of sixteen thousand confinements. It is obvious, however, that such improvement in the prevention of obstetrical disasters is in consequence of the adoption of the following measures:—

1. Availability of skilled medical help and the people appreciating and asking for the same.
2. Institutional confinements.
3. The popularity and feasibility of abdominal deliveries due to the existence of institutions run by qualified individuals as also the availability of modern essential accessories, viz. antibiotics, safe and efficient anaesthetic drugs, blood transfusions, etc.

I have stated above that the popular custom was to look upon confinements as an unclean process. Even during menstruation a woman is taken as unclean. She is not allowed to enter the room where the household Deity is worshipped or where the domestic food stores are kept. She does not do the family cooking. If she does cook at all the respectable elders of the household, particularly the widows, may not take the food cooked by her. Such isolation was strictly enforced during the lying-in period. The room selected was one far away from the living rooms. Amongst the poor, the cow-shed was popularly used. Those who could afford, built a temporary hut for the purpose, and this was destroyed after the lying-in period was over. The new-born's cord was not cut till the placenta was expelled. The cutting was done with a thin piece of bamboo strip. The mother took an elaborate bath within 24 hours after confinement. She was not allowed to drink water freely. The room was kept dark, windows and doors being closed to keep away the evil spirits. A charcoal fire was kept in the room for the first week. Infantile death due to the infection of umbilical cord stump by tetanus clostridium was not infrequent. What with the adoption of urban habits and with the spread of modern knowledge about sanitation a rapid change has taken place. Women raised their voices and such practices have become things of the past. The women's troubles did not end. The midwife continued to be the person in charge; a qualified medical practitioner could be brought in only when she desired to do so. Even lady doctors were not called in to examine and see the patients. Drugs in the shape of roots and concoctions of secret ingredients, supplemented with brutal forceful physical handling of the patient's abdominal wall

and genitalia were utilised to hurry the expulsion of the foetus. I have heard of some queer practices to help the woman to utilize her pains. One such practice was to take the woman's tresses of hair and put them in her mouth in cases where there was delay in the expulsion of the after-birth. This would make the woman get sick and retch and that would hasten the expulsion of the placenta. Pituitrin is a drug which is being abused even now as it was in days gone by. Damages to the pelvic floor remained unrepaired. The midwife was praised if no stitches were put on the perineum. If the perineal skin remained intact even though the vaginal canal might have been torn to ribbons and the pelvic floor grossly damaged, the midwife was congratulated. It is no wonder therefore to find in the outpatients' department young girls coming with gross pelvic floor damage after a first labour. In our undergraduate days, immediate postpartum repair of perineal tears was seldom done in layers, through and through silkworm gut stitches were passed as a routine. Episiotomies have been in vogue only for the last ten or fifteen years.

Much has been said about the uses and abuses of abdominal sections to deliver the foetus. Fifty years ago caesarean sections were rare operations. In teaching institutions, to attract students and nurses, special bells were rung when such an operation was performed. Once the patient got into labour and even if a single internal examination was made section was contraindicated. What a change from this attitude to the things that are happening these days.

In tracing these evolutionary changes, I have kept myself strictly in the domain of obstetrics, that in pregnancy and child-birth. Any discussion about the newborn, premature confinements, interruption of early pregnancy or about gynaecology has not been mentioned.

I conclude with the hope and sincere wish that this distinguished gathering of obstetricians will not feel bored to listen to whatever has been said above. I claim no originality or research work. I shall be amply rewarded if whatever I have written be taken as a record on one's observations during half a century's work in this speciality.