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SIR KEDARNATH DAS MEMORIAL ORATION

by

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Interdependence of Obstetrics and Gynaecology.

I feel honoured at being invited to deliver this the third "Sir Kedarnath Das Memorial Oration" by the Bengal Obstetric and Gynaecological Society. It is a unique honour, not only to be selected to perpetuate the memory of the doyen of Obstetrics in India, but also to feel that your Society should consider me sufficiently senior in experience and standing to class me with those who have given the last two orations. I do sincerely thank you, Sir.

I am not one of the fortunate ones who was privileged to meet Sir Kedarnath. This is a source of sincere regret to me. However, the legacy he has passed on is one which each one of us obstetricians can well be proud of. Sir Kedarnath was held in high esteem even in international circles. Most of his work was devoted to the proper development of Obstetrics, and rightly so, as "preventive obstetrics *is* preventive gynaecology". Sir Kedarnath had a versatile mind and worked on many a problem in both obstetrics and gynaecology. It is evident that he was convinced that the two formed an integral whole and could not be divorced one from the other.

Obstetrics may be said to date back to the origin of life on earth, particularly mammalian life in whom the foetus grows within the uterus till it is mature. Primitive woman followed the practice, still noticed among the animals, of managing her own delivery and disposing off the placenta. We read of midwives in the early days of the Biblical period and it is possible they functioned all over the world. The advance of civilisation and concentration of population in towns brought about problems which required better and organised training. An interesting account of the Evolution of Obstetrics and Gynaecology was given by Leyland Robinson at the William Meredith Fletcher Shaw Memorial Lecture delivered in 1950. The intrusion of "man-midwives", as he terms them, started with Ambroise Pare in the

16th century. The introduction of the midwifery forceps by Chamberlain, early in the 17th century, and Smellie's work, during the 18th century in London, aiming at giving intensive clinical teaching, put the seal on this intrusion. A Chair of Midwifery was established at Edinburgh in 1726. Regular instruction was started, at first for midwives, in France and Italy. It is about the middle of the 18th century that medical students were admitted for this training. The Obstetrician was given the designation of Obstetric Physician or Physician Accoucheur. Gynaecology was still in its infancy and consisted only of palliative treatment. Spencer Wells and Lawson Tait individually worked up gynaecological surgery. It was in 1884 that Lawson Tait helped to found the British Gynaecological Society as opposed to the British Obstetric Society. He wrote, "the day has gone by when the treatment of pelvic and abdominal diseases is to be regarded as a mere appendix to the work of accoucheurs. Gynaecology and Obstetrics are now happily severed." He worked for the establishment of separate Chairs. It was usual to select one with a Fellowship of the Royal College of Surgeons for the Chair of Gynaecology, but this was short-lived. As Leyland Robinson says, "Fortunately the attempt to separate gynaecology from obstetrics was doomed to failure, for all the modern advances in medicine and surgery had shown the biological unity of the two subjects." He goes on to show how the British obstetricians and gynaecologists persevered in their plea and saw to it that these were treated as one subject in all teaching institutions. The foundation of the Royal College of Obstetricians and Gynaecologists in 1929 gave the final touch to this controversy, one of the objects of this Royal College being to prevent the divorce of obstetrics from gynaecology. Similar struggle is noted in the United States of America. The incorporation, in 1930, of the American Board of Obstetrics and Gynaecology marks the formal recognition of one combined speciality. Dannreuther, writing about the origin, progress and accomplishments of the American Board of Obstetrics and Gynaecology, says, "Having been *conceived* in idealism and *born* into the world as a result of *hard labour*, the Board's further activities proceeded from the Articles of Incorporation which state that the chief purposes of the Board are to encourage the study, improve the practice and advance the cause of obstetrics and gynaecology, subjects which should be inseparably interwoven;" and further, "The members of the Board have unanimously believed that the intelligent practice of gynaecology, which is 80% non-operative, depends in a large part upon a thorough knowledge of obstetrics, and vice versa."

Women were almost in clover in Europe in the middle ages. Their emancipation dates back to barely 200 years. However, there are records of work by "medical women" in the Greco-Roman period and later in Italy and France. Esther Pohl Lovejoy puts it succinctly: "Century after century medical men were *writing* about gynaecology and obstetrics, while medical women were *doing* the work." Several women

are said to have taken the doctorate of medicine in Europe. The first English speaking woman to take up medicine was *Dr. James Barry* who, in the guise of a man, took her training and graduated from the University of Edinburgh in 1812, and continued to work as a man, even rising to be Inspector-General of Hospitals. Her sex was discovered only after her death. *Elizabeth Blackwell* was the first who conceived the idea of taking up full training in the U.S.A., but, as none of the medical schools, either in Europe or U.S.A., were open to women, she had to go through almost insurmountable obstacles to gain her objective. A kind Quaker friend even advised her to wear masculine attire, but she persevered in her feminine garb and won her objective. This was 110 years ago, but today every country has medical women in goodly numbers. Quite a good few take up, naturally enough, obstetrics and gynaecology.

The early training schools were mostly concerned with obstetrics, as the high maternal mortality made it imperative to develop better obstetric services. The Department catered for the teaching of obstetrics, in which minor medical gynaecology was included, as even at this stage, the complete divorce of those allied subjects could not be thought of. The development of surgery, and particularly abdominal surgery, brought about revolutionary ideas. The general surgeon felt it his sole prerogative to wield the knife and even when ovariotomy, etc., were introduced they were considered as the privilege of the general surgeon. When it was thought necessary to open special departments of gynaecology these were put under the charge of those with F.R.C.S. as a qualification. Thus in the early days there were the two departments, one under the obstetric physician and one under the gynaecological surgeon, who of course did the caesarean sections for the obstetrician. This system apparently took long to be overcome in England, but in India we were fortunate that from their inception our teaching institutions had the twin subjects under one Head.

The term "gynaecology", as defined in the Oxford dictionary, is "that department of medical science that treats of the functions and diseases peculiar to women," and is thus an inclusive term, as the commonest function is that of reproduction. But old usage of term dies hard and to this day obstetrics is mentioned along with gynaecology, and perhaps it is just as well, if we must not get away from the prime importance of obstetrics which covers more than half the life span of a woman. Gynaecology is thus used today in the limited sense excluding obstetrics. S. R. M. Reynolds has suggested a new term "Gynecotokology" to show the close relationship of the two, gyne meaning "female" and toko is "pertaining to birth."

Colleagues of my generation who are present today will recollect how much of the back-breaking gynaecological work of our time, was the aftermath of bad obstetrics. If some of these, as V.V.Fs., still crowd up the gynaecological department, I expect they hail from rural areas where proper obstetric services are lacking. The prevention and minimisa-

tion of the effects of puerperal sepsis has gone a long way towards reducing cases of chronic inflammatory adnexal masses, which usually involved dense adhesions to the parietes, omentum and intestines, needing meticulous care.

The affinity of obstetrics and gynaecology can be vividly realised when we, as gynaecologists, successfully treat a case of sterility. Would any of us like to pass this on to another for care during pregnancy and labour? Do we not feel sufficiently interested in the patient to help her through this ordeal? And are we not interested in that no mishap occurs and that the right procedure, even a caesarean section if needed, is carried out both in the interests of the mother and infant?

Following the course of a normal pregnancy and labour may be considered mundane, but we must remember that *that* was the goal of the treatment we started with when the woman came to us for sterility. Some of you will recollect cases where a woman has prolonged sterility after each child, and we are called upon every time to help her to conceive. This to my mind is the most illustrative case for close correlation of obstetrics and gynaecology.

Most of our work among women is in the child-bearing period and we, as gynaecologists, are ever vigilant to preserve the child-bearing functional status of their reproductive organs. Thus conservative gynaecological surgery, as sponsored by Victor Bonney, is held constantly in our minds. Gynaecology and obstetrics may be considered to move in a cycle, each bringing up the other in its wake. Congenital abnormalities may form an illustration. Atresia in the genital tract may have to be overcome to give an easy passage to menstrual fluid and to sperms. Acquired atresia, the result of difficult labour, will involve ingenious gynaecological procedures to help possibility of future conception. Operations for prolapse, urinary fistulae and other like conditions, aim at restoring the woman to her normal state with possibility of conception in future. Ectopic gestation brings in special problems. It is difficult in some of these cases to know where obstetrics ends and gynaecology begins and vice versa. Next, take the cases where pregnancy is complicated by an ovarian or uterine tumour. Must the gynaecologist be called in by the obstetrician to deal with these tumours? It is a recognised convention that, if during a pelvic operation the appendix is required to be removed, the gynaecologist carries on. The general surgeon is not summoned at this stage. The same person who is competent enough to deal with major obstetric problems, including abdominal section, must be competent enough to deal with whatever else presents during the operation. It is essential that a gynaecological surgeon should be well versed with general abdominal surgery, particularly intestinal surgery, as often one may be confronted with dense intestinal adhesions in the pelvis. The recently introduced operation of exenteration for carcinoma of the cervix requires a thorough knowledge of the surgical anatomy of the bladder and rectum, not to speak of the pelvic vascular and nervous systems. To go back to cases of sterility various ope-

rative procedures have been introduced to meet different problems. Ventri-suspension had been considered a necessary treatment for sterility associated with retroversion. Happily enough this trend is declining, except in the case of the young aspirant gynaecologist who would like to make a flare by piling up operation lists! Dilatation and curettage has also been given a limited place in cases of sterility, particularly since the introduction of tubal insufflation by Rubin. Tubal operations are being advocated in some cases, but here again one wonders how far the claim that there is blockage at the interstitial end of the tube, when the rest of the tube is healthy, is correct. Even skiagrams can give a fallacious idea in the presence of spasm. I feel that every one doing such operations should send a piece scooped out of the uterine cornu for section to prove the block. A factor that is often omitted in cases of sterility is the treatment of the ovaries. In quite a number of cases of sterility, even if there is a retroversion, the ventri-suspension may be considered a secondary operation, the main treatment which relieves the sterility being the wedge resection of the ovaries, where the follicles have not been rupturing. One may be justified in suggesting this procedure, even if the uterus is anterior, provided one has proved the non-ovulatory cycles by observation over a few months. An alternative treatment for such cases, and reported on favourably, is low dosage X-ray therapy (Kaplan's treatment) to pituitary and ovaries. This, of course, is a matter of opinion.

I have just given a few instances where obstetrics and gynaecology dovetail into one another. It is obvious that physiological and pathological conditions of the same organs must go hand in hand, the great objective being the preservation of the main functions of these organs and prevention of diseased conditions. Congenital and acquired defects, as shown by Shirodkar in the case of the incompetent cervix, can be taken as another instance of the necessity for a close combination of these specialities in one individual.

The question would arise, if every one practising midwifery should necessarily be a gynaecological surgeon. In our subjects we must allow a place for the general practitioner who will deal with straightforward midwifery with limited scope for vaginal operative deliveries. The same person would be responsible for the ante-natal care of the individual and for proper follow-up after delivery to ensure that the function of lactation is carried out satisfactorily to the advantage of the infant, and to help the woman to regain her normal non-pregnant state, an achievement which requires much vigilance and guidance. Women of the present generation are particularly conscious of their figure. This you may think is the physiotherapist's concern. However, our responsibility as obstetricians towards preventing the aftermath for gynaecology is certainly great. Blair Bell had said that 60% of gynaecological work is the result of bad obstetrics. This percentage has declined since we have been able to reduce the incidence of puerperal sepsis, but what of the result of septic abortion, often brought on by illigitimate means?

Do you recollect cases of sterility which give a history of having had abortion procured in the early years of marriage? — cases so difficult to help. These are the ones where the cornual ends of the tubes are blocked, as shown by Green-Armitage. Is it not our responsibility to try to educate the population against such practices? In the early years when family planning was being advocated and contraceptives were being advised, cases would come to us, either on their own or worse still brought by general practitioners, cases who had conceived and felt that, as part of family planning, abortion should be induced! The incidence of abortion has been variously worked out as 15-25% of deliveries, but even this may be an understatement, for a number of cases do not come to our notice and history-taking with our ignorant population is so unreliable. Apart from the natural causes, it is surmised that quite a large number are either self-induced or procured, and these are the ones which end in disaster. If the woman survives the ordeal, she has probably already got damage done which prevents further pregnancies. Venereal infections seem fortunately on the decrease and thus the incidence of gonococcal infection of the adnexa has declined.

We, as obstetricians, must take up post-natal work seriously and develop it so as to ensure a return of the parturient woman to the normal non-pregnant state. We have managed to make ante-natal clinics very popular all over the country, albeit the heavy attendance at these is largely due to the fact that women find it more convenient to have confinements at hospitals, and they realise that they must book early to ensure admission for confinement. I have already dwelt at length elsewhere on re-orientation of ante-natal work so as to make it really educative both for the patient, medical student and the pupil-midwife, and thus incidently, prevent many a complication of pregnancy and labour. Health visitors and medical social workers keep vigilant watch over the attendance at ante-natal clinics, but they would need to persevere with their efforts at popularising the post-natal clinics. We on our part should see that a fairly senior person from the Unit attends these clinics to attract better attendance. This is certainly uphill work but well worth the reward, if we are truly interested in preventive gynaecology. A very interesting paper was written on *"The Prevention of Prolapse of the Uterus and Vaginal Walls following Childbirth"* by Margaret Salmond and Gertrude Dearnley in 1935, giving an account of follow-up of 580 patients, cases collected from hospitals attended by students and midwives, cases of general practitioners and private cases of specialists. They noted that there were fewer cases of prolapse and lacerations in the private cases and they implied that poor nutrition probably played a prominent role in bringing about this laxity of tissues. Moreover, premature and strong bearing-down efforts, long before the onset of the second stage, and attempts at forceps delivery even before full dilatation of the cervix seemed responsible for a large percentage of these defects. A careful follow-up in the immediate puerperium and during the first six weeks,

guiding the woman with the right type of exercises, instructing her to avoid constipation and undue strain, will go a long way to prevent prolapse and stress incontinence. A condition easily preventable is *chronic retroversion* in a multipara—a displacement associated with menorrhagia, leucorrhoea and chronic backache. This is definitely an aftermath of neglected post-natal care, which has allowed a heavy subinvoluted uterus to fall back and bring about this train of symptoms. Careful guidance during the early puerperal period, regular exercises including knee-chest exercises for the first month, avoidance of strain and constipation and, most important of all, a timely post-natal examination, say at the end of the first month, will help to detect this condition and give an opportunity for early and permanent cure by conservative methods. I have often helped these women to conceive and then ensured proper post-natal care, as detailed above, so as to give a permanent cure. A number of unnecessary ventri-suspensions can thus be prevented. Similarly, early lesions of the cervix and vaginal walls can be looked for soon after labour and at post-natal examinations, and proper treatment instituted so as to prevent chronic conditions, particularly of the cervix, which if neglected may form a precursor to carcinoma of the cervix.

Castello and Montgomery published an interesting paper in 1935 on "The Management of the Prenatal and the Postnatal Cervix". They emphasised the need for prenatal treatment of cervical lesions to prevent puerperal infection, and postnatal follow-up for detecting and treating cancer. To quote them, "To precisely the same degree that prenatal treatment of the infected cervix is necessary for the prevention of puerperal infection, so also is postnatal restoration of the cervix required for the prevention of cervical cancer." They advocated periodic examination. Tompkins, in the same year, gave the "Results of Treatment of Benign Lesions of the Cervix Uteri by Cauterisation, Trachelorrhaphy, Sturmdorf's Operation and Amputation of Cervix" and stated that the incidence of carcinoma of the cervix was very low in these cases, 2 out of 611. H. S. Crossen, writing in 1933, remarked that *results of treatment* of carcinoma of the cervix had got to a standstill, because it was symptomless in the early stages and advice was often sought too late. This statement is perhaps true even today. Crossen suggested prophylaxis by: 1. Early treatment of irritation of the cervix. 2. Regular follow-up. 3. Leading questions about leucorrhae, etc., even if patient comes for other complaints. 4. Routine pelvic examination even if patient has not come for symptoms pertaining to the pelvic organs. 5. Yearly examination between 35 and 55.

The routine examination of the cervix has exercised the minds of gynaecologists for at least the past 30 years. Hinselmann introduced the Colposcope in 1928. This was followed soon after by Schiller advocating the Lugol's Iodine test and biopsy of suspicious areas. The credit for the latest development goes of Papanicolaou. Cytological diagnosis is now being worked up at all centres and is proving very helpful.

Periodic examination in the cancer age is a responsibilily of the gynaecologist, a practice which it is incumbent on every gynaecologist to popularise among his patients. Fortunately, the general population is getting cancer conscious and a number of these can be easily influenced to attend periodically. Such prophylactic work is our responsibility and should find a prominent place in our teaching of undergraduates and postgraduates. Apart from this, every woman needs to be instructed as to the symptoms she should not neglect.

This brings me to the subject of *teaching our speciality*. We are all agreed that every aspiring medical person should have a good grounding in obstetrics, as reproduction is the commonest function, and affection, if you wish to put it that way, in the childbearing period of a woman. The percentage incidence of neoplasm of the generative tract is fortunately much lower as compared to conception. As already stated a high percentage of gynaecological work is the aftermath of bad obstetrics and hence good obstetrical care will go a long way towards reducing this incidence, leaving the gynaecologist to deal mostly with neoplasms and certain functional disturbances. It will be conceded that some neoplasms, as carcinoma of the cervix, and some of the functional conditions are possible to be either prevented or at least detected in their incipient stages so that complicated operative procedures can be prevented. Sufficient time of the student should be devoted to the study of obstetrics and hence, I feel, it is essential that the teacher spends time over giving training in normal ante-natal, intra-natal, immediate puerperal and post-natal work, emphasising all along the preventive aspect. The concept of the management of ante-natal work, as I have already stated, has to be completely re-orientated to see that the clinic is educative both to the patient and the student. Following of labour cases again has to be worked out with a view to getting the prospective doctor to be fully in alignment with the case he is to conduct, rather than come in just in time for the second stage. Follow-up of mother and infant in the lying-in wards is just as important. Post-natal clinics can afford much scope for training in preventive gynaecology, and thus need to be popularised among the patients and students. I have noted with dismay that very few obstetricians make it a point of impressing the need for a follow-up on the patients confined by them. Our responsibility does not end with seeing the woman through her confinement, but one may say that, once we have won the confidence of the patient by the way we managed the labour, we are in a position to impress on her the need to continue under supervision.

It has been conceded by all that six months should be given for our speciality in the undergraduate training, and of these, two-thirds of the period should be devoted to obstetrics. The aim of undergraduate training is to prepare a good general practitioner who can attend to the general ailments in the population, and at the same time carry out prophylactic examinations and propaganda. Every general practitioner is called in some time or the other for labour cases, particularly if there is

delay, and hence it is essential for him/her to be well versed in obstetric diagnosis and management. Fletcher Shaw quotes Sinclair as having said that "Students are taught surgery which they will not practice and later practice midwifery which they were not taught." Gynaecological work as such will be of the nature of conservative work, but it is essential that the general practitioner is able to detect the earliest deviations, in every branch of medicine and surgery as well, so as to refer the cases for specialist advice in good time. It is thus not necessary for the undergraduate to spend long hours in the operation theatre watching complicated operations. The major part of his time can be spent profitably in the out-patients' department, and in the wards seeing patients and following the line of treatment advocated. He will need to see a few simple operations, to be able to realise the correlation of pre-operative diagnosis with actual findings, and get an idea of some of the procedures which might have been prevented if the patient had received proper obstetric care. The teaching, mostly of the nature of discussions rather than didactic lectures, should constantly correlate obstetrics and gynaecology, rather than treat them as separate compartments. Fred Adair's "Obstetrics & Gynaecology," in two volumes, is a good illustration of such correlative teaching.

The post-graduate can well get an intensive grinding in normal obstetrics ere he/she goes on to the study of deviations from the normal. He must needs study clinical findings and the choice of treatment for each, learning to carry out various therapy, including operative work, under expert guidance. He will be the future teacher of the speciality, not only to aspiring medical students but even to the prospective teachers and specialists, as also to the public, thus aiming at keeping each woman passing through his care in as healthy a condition as possible. His will be the prerogative of evolving newer methods of treatment, including surgical procedures, and to carry out research projects in our speciality. He may get thoroughly engrossed in these and find little time for the physiological aspects of our work.

This is the age of team work. One can well imagine a team consisting of one or two specialists, a couple of general practitioners with a bias for obstetrics, and a number of midwives and social workers, who can take up respective responsibilities and yet not feel isolated, for they can each have the benefit of the advice and guidance from the seniors and at the same time the seniors can be kept acquainted with the day to day problems arising in the work of the general practitioners, midwives and the social workers. Regular weekly discussions among the staff of the clinic can help each to keep abreast with the times.

Medicine has developed fast during this century and innumerable specialities have come up and promise to further crop up as time goes on. If we must keep up with this advance in our knowledge which has a bearing on our work, we must keep in close collaboration with the general physician, general surgeon, pathologist, radiologist, anaesthetist and pediatrician to be able to get the benefit of their knowledge which

would have a bearing on some of our problems. Howard Taylor (Jr.) has said, "The evolution of obstetrics and gynaecology away from a speciality anatomically defined, towards one based on a broad idea is a great accomplishment, but the abandonment of tangible means of defining our frontiers has made us particularly susceptible to invasion by other disciplines. Co-operation with them has indeed become imperative." He ends up his address with the statement, "The union of obstetrics and gynaecology is an article of faith with most of us, but it has produced requirements in knowledge and skills that stretch the human capabilities to their utmost. Between the extremes of cancer of the cervix and the toxaemias of pregnancy lies most of medicine."

This gives much for us to ponder over the preparation for, and particularly the practice of, our speciality. Ancillary aids will always be welcome. Our speciality, particularly as it comprises a fundamental aspect of human physiology, viz., that of reproduction, closely correlates with preventive and social medicine, and thus places a great responsibility on us for good obstetric work, which will go a long way towards preventing many a gynaecological ailment. This realisation can only come if the two subjects are considered as a whole forming one speciality, taught and practised as such.

I admit I have not given out new ideas, which some of you may have looked forward to at this Oration, but I am convinced that not enough can be said on the subject of correlation of these twin subjects, as also on the prevention of unnecessary suffering to women. The modern trend of young gynaecologists is towards complicated operative work which certainly is fascinating for the operator but eventually the greater achievement to our credit should be *the prevention of the need for such operative procedures.* If this idea goes home to some of my young friends present this evening and to a larger number who may read this in the journal, I shall feel it was worth my while coming over for this Oration. Thank you.

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