THE
Journal of Obstetrics & Gynaecology of India

VOLUME XIV, No. 1 MARCH 1964

PRESIDENTIAL ADDRESS

by

M. K. KRISHNA MENON, B.A., M.D., F.R.C.O.G., F.A.M.S.

Permit me first to express my deep gratitude for the honour you have conferred on me in electing me to the presidentship of the Federation. On this occasion, it is the privilege of the president to inflict on you his ideas, if he has any, on problems in our speciality and particularly the ones that in his opinion may be termed burning problems.

For over 25 years it has been my fortune to dabble in the speciality of obstetrics and gynaecology. These years have been monumental in history and medicine. It saw the birth of chemotherapy closely followed by the anti-biotics, the establishment of organised blood transfusion services, improvements in anaesthesia and surgical procedures and harnessing of atoms into medicine. The impact of such advances could not but affect the ultimate in medical science. Obstetrics and Gynaecology had also their share.

Whatever be the nature of advances in obstetrics, its result is always best assessed by maternal and perinatal mortality rates. It is now well-known that because of the developments our maternal mortality rate has been reduced to a fifth or less of what it was 25 years ago and perinatal death rate has been reduced by about a half. These are very encouraging but when compared with technologically advanced countries these rates are still very high. I do not wish to go into a detailed analysis of the various factors which keep these rates high except to state that in general it is due to (1) poor socio-economic standard, (2) lack of education and hence inability to realise the value of antenatal care, (3) non availability of antenatal care to a very large section of the population, (4) indifferent quality of available antenatal and intranatal care, (5) lack of co-ordination between domiciliary and institutional services, (6) poor or no pediatric care. In a vast country like India to set right all these is a Herculean task.

While I am not in a position to discuss what should be done to improve

Delivered at the XIIth All India Obstetrics & Gynaecological Congress at Ahmedabad on 12th December 1963.

the socio-economic and educational standards of the nation, I cannot but help state that unless these two important factors are improved, the developments in obstetrics and gynaecology will not bear full fruit. As specialists our duties are mainly confined to patient care, training of those who undertake to look after these patients and research. India is a vast country. We are — comparatively — technically, a developing country. Even today it is not possible to obtain correct data on births, deaths and causes of death even in the big cities. More than 75% of the population remain rural. The law of the land requires registration of births and deaths. A death certificate is also said to be necessary. The cause of death may be anything depending on what the medical practitioner feels is the cause of death. The enforcement of the law leaves much to be desired and unless post-mortem examinations are made compulsory, we cannot make much progress in prevention and cure. It will help advancement of medical science, which will help to save more lives, if state governments will enact a law making post-mortem examination compulsory.

In our country where the majority belong to the low socio-economic class, with grossly inadequate hospital services and still more inadequate number of specialists, midwifery is and will have to be largely domiciliary in character. May be institutional midwifery for all gives the best results as regards safety to mother and child but for years to come it can only be a dream to us. Hence the importance of domiciliary services to us in our present state.

To what extent are our existing *domiciliary services* satisfactory? In the cities and in some of the major towns the corporations and municipalities run their own domiciliary services usually centred around a number of maternity and child welfare centres scattered in the area. These centres are staffed with lady doctors and midwives. They do routine antenatal care and the midwives conduct the deliveries in the houses of patients or in maternity centres with attached beds. When anything goes wrong during parturition an ambulance is summoned and the patient taken to hospital. At times when delivery gets delayed, the relatives summon the midwife to the house who if she cannot effect the delivery takes the patient to the hospital. More, often when delivery does not take place, the relatives themselves take the patient to hospital. The further management of the case is left to the hospital staff. This is one form of domiciliary midwifery.

Efficient maternity care includes antenatal, intranatal and postnatal care. The crux of modern antenatal care is the assessment of all unfavourable factors during pregnancy and prior to labour. With such assessment made, complicated cases are diverted to hospital, even in the early stages and surprises during labour are reduced to the possible minimum. When complications do occur the staff is ready to deal with them as they have been anticipated. If that is modern maternity care it is not proper that antenatal care should be done by one set of doctors and midwives and when complications arise in labour by a different set, as these

patients are transferred to hospital where the attending staff comes into contact with the case for the first time. Antenatal, intranatal and postnatal care are all one continuous process. The word 'Booking' for delivery means that such continuity of service is offered and accepted. As it is now, in most of the areas in our country there is no co-ordination between the domiciliary and institutional services. One of the factors that helps to keep up our maternal and perinatal mortality rates still so high is this lack of co-ordination. In my hospital nearly 75% of the deliveries are 'unbooked' and 90% of the maternal deaths are among these unbooked cases brought into hospital after hours of prolonged and mismanaged labour elsewhere.

Is it not possible and is it not time to integrate the two services? Is it not possible for the cities and towns to be divided into three or four areas according to the situation of the major hospitals? Could not the maternity and child welfare centres under the corporations or municipalities be then, according to the area of their situation, attached to each of the major hospitals so that the work of these centres could be supervised or conducted by visits of at least the junior specialists from these hospitals? I am sure many will agree with me when I state that the staff of our teaching hospitals have little knowledge of domiciliary midwifery. Equally the medical officers working for years in the domiciliary services of the corporations and municipalities have only a limited knowledge of modern institutional midwifery and the more recent developments in our speciality. An interchange of the junior staff of hospitals and of the maternity and child welfare centres for short periods will not only, in my opinion, improve the standards of domiciliary midwifery but will also help in integration, progressively of the two services which really should be one. As it is now, these two services are widest apart. The standard of domiciliary midwifery necessarily depends upon the professional standards of the medical officers and midwives in these centres, in addition to facilities available. Therefore it becomes mandatory that all officers in the domiciliary services should have periodic refresher courses in training institutions if the standards of domiciliary services are to improve.

There is yet another type of domiciliary service. In the rural areas and villages and even in some district headquarters, antenatal care is seldom routine. Firstly the expectant mother is not educated enough to understand the important prophylactic value of antenatal care and equally there are far few doctors to give such care even to mothers who seek it. Hence the doctor is called in only in an emergency-usually haemorrhage, convulsions and obstructed labour. And who is the doctor who attends on her? Ninety-nine times out of hundred it is the harassed and over-worked general practitioner whose only training in obstetrics is what he obtained as a student in the final year of his study, years ago at the medical college. It would be in the interests of all concerned if the general practitioner is encouraged to undergo refresher courses in the speciality if emergency obstetrics is

to improve. The government could encourage them by financial help to undergo such training considering the valuable services they would be rendering.

All that I have talked about doctors, their standards of training and necessity for refresher courses apply with equal, if not more emphasis, to the midwives and health visitors also who form the backbone of the domiciliary services. Their standards also should be stepped up by periodical training, side by side with the doctors. And we require a very large number of such well-trained midwives. This takes me on to the problem of the specialist in obstetrics and gynaecology and the content and aim of postgraduate education in our speciality.

Postgraduate medical education has become a burning problem today. Medical colleges are being opened in large numbers. There is a great dearth of qualified teachers to man these institutions; a great rush therefore to obtain a postgraduate degree in the speciality of one's choice; a tremendous hurry to get a degree and, need I say, also a sad tendency to lower the standards to meet the increasing demands. In general all our universities have almost the same pre-requisites essential for entering the postgraduate courses and taking the examination, namely one year of house surgeoncy in medicine and surgery followed by two academic years of training in the speciality under a recognised professor in a recognised institution. In some universities, like Madras, the Diploma in obstetrics and gynaecology, which can be taken after one year of training subsequent to a year of general house surgeoncy, is pre-requisite before a candidate can be admitted for the two year training leading to the degree. We cannot but admit that there are wide variations in the type of training and what is more in the standard of examination also.

It is an oft-quoted saying that everybody knows more about obstetrics and gynaecology than the obstetrician and gynaecologist himself. The general surgeon is contemptuous of our knowledge of surgical conditions within the abdomen and does not spare us his sneers. The obstetrician has interested himself in the medical diseases complicating pregnancy, since the proper management of the pregnant patient makes such knowledge essential. The toxaemias of pregnancy have always been diagnosed and managed by the obstetrician and most of the research on this problem has been conducted by him. But now the physicians have become interested in these and they seem to know more about these than we do. The pediatrician wants to take over the baby not only at birth and after but also, if possible, during pregnancy. The anaesthetist wants to take over the resuscitation of the asphyxiated baby. The radiologist by virtue of his dealing with radiation believes that the treatment of female genital cancer should be his responsibility. The urologist believes that the repair of urinary tract fistulae is his province. The fashioning of a vagina is being taken over by plastic surgeons. The endo-crinologist affirms that for all menstrual abnormalities he is the solution, while the psychiatric specialist runs a very close second to him

patients are transferred to hospital where the attending staff comes into contact with the case for the first time. Antenatal, intranatal and postnatal care are all one continuous process. The word 'Booking' for delivery means that such continuity of service is offered and accepted. As it is now, in most of the areas in our country there is no co-ordination between the domiciliary and institutional services. One of the factors that helps to keep up our maternal and perinatal mortality rates still so high is this lack of co-ordination. In my hospital nearly 75% of the deliveries are 'unbooked' and 90% of the maternal deaths are among these unbooked cases brought into hospital after hours of prolonged and mismanaged labour elsewhere.

Is it not possible and is it not time to integrate the two services? Is it not possible for the cities and towns to be divided into three or four areas according to the situation of the major hospitals? Could not the maternity and child welfare centres under the corporations or municipalities be then, according to the area of their situation, attached to each of the major hospitals so that the work of these centres could be supervised or conducted by visits of at least the junior specialists from these hospitals? I am sure many will agree with me when I state that the staff of our teaching hospitals have little knowledge of domiciliary midwifery. Equally the medical officers working for years in the domiciliary services of the corporations and municipalities have only a limited knowledge of modern institutional midwifery and the more recent developments in our speciality. An interchange of the junior staff of hospitals and of the maternity and child welfare centres for short periods will not only, in my opinion, improve the standards of domiciliary midwifery but will also help in integration, progressively of the two services which really should be one. As it is now, these two services are widest apart. The standard of domiciliary midwifery necessarily depends upon the professional standards of the medical officers and midwives in these centres, in addition to facilities available. Therefore it becomes mandatory that all officers in the domiciliary services should have periodic refresher courses in training institutions if the standards of domiciliary services are to improve.

There is yet another type of domiciliary service. In the rural areas and villages and even in some district headquarters, antenatal care is seldom routine. Firstly the expectant mother is not educated enough to understand the important prophylactic value of antenatal care and equally there are far few doctors to give such care even to mothers who seek it. Hence the doctor is called in only in an emergency-usually haemorrhage, convulsions and obstructed labour. And who is the doctor who attends on her? Ninety-nine times out of hundred it is the harassed and over-worked general practitioner whose only training in obstetrics is what he obtained as a student in the final year of his study, years ago at the medical college. It would be in the interests of all concerned if the general practitioner is encouraged to undergo refresher courses in the speciality if emergency obstetrics is

in the diagnosis and treatment of such conditions. It is indeed strange that such aggression, benevolent no doubt, should have taken place in our speciality. We have to pause and ponder why it is so and if we are to survive as a speciality we have to educate and train our postgraduates in such a way that they would get a basic training in all these disciplines which have made inroads into our speciality.

This necessarily means that we have to reorientate the training of the future specialists in obstetrics and gynaecology. In addition to the usual anatomy, physiology and pathology he should have — to mention a few — a basic knowledge of radiation and current views on it, psychosomatic medicine as applied to our speciality, physiology of the newborn infant in general, placental transmissions, biochemistry of hormones and now of course the chromosomes. In any good training programme these studies must be incorporated so that the clinical and practical aspects of the training may rest on sound basic principles.

If it is agreed that these subjects should form an integral part of the education and training of a specialist, the next question is what is the minimum period required for such training. Is the present two year period sufficient? While I am averse to recommend unnecessary increase in the years of training before a specialist can be turned out, I am fully conscious of the inadequacy of a two year training period. Probably three years in my opinion is the minimum period required.

May I be permitted at this stage to diverge a little. What I have stated above is the standard that should be laid down for the future specialists who are to man our teaching departments. But we have to consider the very large number of specialists required for service in the country other than in teaching hospitals. I am visualising the time when at least all the major non-teaching hospitals will have on their staff specialists in obstetrics and gynaecology. Should these specialists also undergo the same three year training, which is really meant for an academic career? While it would be desirable it would not be easily possible for some time to come to staff all our hospitals with such specialists. What is required in the non-teaching hospitals is a specialist with a high standard of clinical and practical excellence. In other words would it not be worth while to take up those who are interested in this speciality, give them sound training in teaching hospitals on essentially clinical and practical lines, shall I say for a couple of years, and then make them suitable to serve as specialists in non-teaching hospitals?

In the last twenty-five years obstetrics and gynaecology has undergone radical changes. The fundamental researches and advances in ancillary subjects and basic sciences have made great impact on the speciality. Many universities are now thinking in terms of having an examination in basic sciences as a pre-requisite to the final postgraduate examination. That the standards of examination vary is well known. It is also well known that the failure and success rates vary widely in the different universities. I shall not go into a

detailed analysis of this phenomenon except to point out that there are three factors involved: (1) the material *i.e.* the student, (2) the machinery for training *i.e.* the teacher, his training programme and facilities available and (3) the examiners. These factors vary from university to university. I frankly ask, in general, are we selecting the best of the candidates who apply for training? If we can select — there are so many reservations of various types these days — the best available candidates, and the teachers and facilities for training are reasonably good, I see no reason why the results should not be excellent. There is of course the unwept, unhonoured and unsung bunch of examiners who are always victimised for poor results. Examiners are famous for their oddities and the delight they indulge in, in pulling down young aspiring specialists. In all fairness to both candidates and examiners I must confess that, with my experience of postgraduate examinations in a number of universities in India, I am fairly convinced that most often it is the examiners who fail to pull the candidates through. I know of one common comment on these examinations. Why have them at all? I shall not discuss it except to state that under present circumstances it is a necessary evil and there is no better alternative.

There is a general tendency to take in a large number of candidates for training, for the country requires a large number of specialists. Such large numbers, if taken in, necessarily mean very inadequate training, lowered standards and poor results in examination. I think that instead of the number taken in for training the emphasis should be on the output and not on the intake. Is it not better to take in only a reasonable number for training with a good chance of at least three-fourth of them getting through rather than take large numbers with few or none getting through? It would be a sad day for our teaching institutions if they are to be staffed with inadequately trained substandard specialists.

A word about *research.* It should be the aim of every training centre to stimulate the students to research work. Research is of two kinds — fundamental and clinical. Fundamental research is of supreme importance but unfortunately not many are gifted and equipped for such research. Equally important is clinical research. This is a type of work which every member of the teaching staff could and should indulge in and is very important not only from the point of view of teaching but also from that of the community of patients. Many of us today are not equipped or have had the training for fundamental research. But that should not deter us from carrying out clinical research for which in India there is immense scope. Facilities for fundamental research are gradually being built up in our institutions. Since independence there has been a resurgence and fundamental research of no small calibre is being done in our country. I am visualising the time when each department will have a research professor with a well-equipped laboratory and technical staff to work in close collaboration with the clinical professors. Such a

situation will further stimulate the young postgraduate to put out his best. The professor in charge of postgraduate training should be permitted to pick out the promising ones for further training so that he can have a number of such trained persons to distribute all over the country and to succeed him also. Such encouragements to our young men will pay high dividends and if in academic appointments merit be the only consideration — which at present it is not — the future of our institutions and the standard of our medical education will be improved and preserved.

It is necessary to emphasise that medical education is a continuing process. Unfortunately there is visible a sad tendency to relax and take it easy after a postgraduate qualification is obtained and an appointment on the teaching staff is confirmed. Such a tendency is detrimental to further progress and in a teacher it is inexcusable.

Many thoughts come to my mind. There are many problems which require urgent attention — cancer control, family planning—to mention only two, but I do not wish to give expression to them. I have expressed myself broadly and briefly on two of the important things that are uppermost in my mind—improvements in our obstetric service and postgraduate education in our speciality. Many schemes are afoot regarding improvements to our medical institutions and public health and social services. We unfortunately meet under an emergency. At the moment we cannot foresee how this is going to affect the developments in the third plan. Even so we cannot give up our ideas of improvements.

In these improvements the Federation can play a vital role. In problems pertaining to education in our speciality and improvements in obstetrical and gynaecological services to the country it should be in a position to advise the Government or its representative bodies. One of the very urgent needs is the standardisation of our postgraduate examinations. All know standards vary with universities. Universities are autonomous bodies and it will be presumptous on our part to advise them. The Medical Council of India has its committee on postgraduate medical education which I understand is now seized of the problem of standardisation. There is now the newly established Indian Academy of Medical Sciences which also is similarly concerned with the academic aspects of medicine in all its branches. There are thus many agencies with one aim. It would be most helpful if these bodies could co-operate and co-ordinate their activities. I believe that the Federation of Obstetric and Gynaecological societies of India can play a vital role in these matters as far as our speciality is concerned for the Federation represents the entire body of obstetricians and gynaecologists of the land.