

XVIII ALL INDIA CONGRESS OF OBSTETRICS AND GYNAECOLOGY

PRESIDENTIAL ADDRESS

by

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My Obligations

I take this opportunity to express my sincere thanks to all of you who have given me this signal honour by electing me as your president and preside over the deliberations of this Eighteenth All India Congress of Obstetrics and Gynaecology, more so when I know that I am the first president of the annual conferences to follow in future.

Obstetricians and Gynaecologists of our country have been meeting regularly every two years since we met first time in Madras in 1936 under the able stewardship of Late Dr. Ida S. Schudder. Our Biennial Conferences have been a regular feature except when disturbed by uncontrollable circumstances. The Federation was established in the year 1950 and will celebrate its Silver Jubilee next year. Our Organisation is the largest medical specialist organisation with a membership of about 2000 members with 41 affiliated societies in all big cities of India. Internationally we enjoy a position of strength and importance with our membership strength ranked third amongst 76 National Organisations affiliated to the International Federation of Obstetrics and Gynaecology. The Federation has sailed the ship successfully in the calm, serene and occasionally rough waters leading to progressive solidarity.

City of Manipal is one of the few new cities of India. It can be called modern Banaras, the city of learning. With the Medical College, Dental College and

College of Pharmacy, Manipal enjoys many important distinctions. The city where largest number of medical conferences have been held in recent years. It attracts largest number of medical students from various parts of India, the neighbouring countries and even from distant lands. This is all because of dynamic vision of the Pai Family. All of you will be impressed when you learn the great progress achieved by this city in the fields of scientific and academic activities.

Since last three decades the Art, Science and Social aspects of Obstetrics our speciality. It is inconceivable to paralleled progress in various horizons of our speciality. It is inconceivable to think when we practise how helpless we are without the active co-operation and help from Physicians, Paediatricians Surgeons, Neo-natologists and of course Diabetologists, Cardiologist and Endocrinologists. The corollary to this could be a conference of a nature where academically interested medical men can meet and exchange views and ideas and discuss their implications. As a sect of privileged physicians we have eyes that perceive, ears that calculate, hands that feel and are hardly felt and hearts which join our minds in our concern for the patients, whose attitudes are our aptitudes which will sense the deep appreciation of our profession. We are judged by our personal behaviour, professional ability, sacred philosophy and humane approach.

There is a phenomenal transitional

change in obstetric care from the poor ill-trained, untrained and discordant Dai to the complete obstetric care accorded now which demands our indulgence from Womb to Tomb or Conception to Con-solation in the end. Total care of repro-ductive era of women is our mission of life which means solution to problems of adolescence and puberty, pre-natal, intra-natal and post-natal cares vigilance to observe and guide the new born's beha-viour and attitudes, diagnose and treat adequately gynaecological problems, ex-tensive practice of sterilisation when demanded, tackling of pre-menopausal symptoms and face the menopausal period including total care of malignant condi-tions if they develop. There are many dusky clouds on the horizon when tackl-ing such heavy responsibilities with spiralling price rise in the cost of drugs, increasing cost of laboratory investiga-tions, rising cost of bed maintenance and ever rising cost of living index and short supply of life saving drugs and appli-ances.

Our speciality aptly called "Twin Spe-ciality" demands care of two lives with single payment in return. It is medically and surgically oriented and we have to demonstrate our competence before being qualified to receive our dues, and hence our speciality is Dimorphic in nature. Good medicine is a matter of art, judge-ment, competence, sympathy, morality, courage and forbearance. Lack of same renders medicine rather a business than a profession. Serious and sincere obstetric care entails constant stress and strain during the whole pre-natal period till the safe delivery of the new born and there-after face the problems like genital haemorrhage at any time. Threatening and impending abortions, termination on demand, the unsuspected perilous ec-

topic hazards, various facets of develop-ing toxæmia leading to eclampsia, pre-mature delivery, a great obstetric dilem-ma, modern stress and lay educational magazines knowledge leading to uterine inertia, exhaustion, ending in desultory progress of labour, sudden and unpredict-able challenge of abnormal presentation or position, impending fears of intra uterine death (silent death), haranguing problems of cephalopelvic disproportion (suspected or unexpected), devastating problems associated with congenital ano-malies, teratogenic or otherwise, prob-lems of cerebral palsy, unexpected post partum haemorrhage, sudden sponta-neous inversion of uterus and pelvic in-fection, from amnionitis to septicaemia. We have to survive all these oddities of nature to become a successful and satis-fied obstetrician which means constant anxiety, eternal vigilance, ignoring the pleasures of family life with cherished hopes of lucrative practice and popularity leading to fame, name and funds.

This means education and training in our speciality should receive careful, select and close attention into our whole medical curricular training. It means a constant provision for adequate and ex-haustive postgraduate education in the practice of obstetrics and gynaecology under sincere, well trained and well motivated teachers with exemplary devo-tion to duty. Over-worked as we are, this ideal aim of our training programme is a myth. Continuous training and education of our young and aspiring colleagues is the real challenge which has to be accept-ed by our Fédération and Member Bodies. There is a constant cry due to lack of availability of resident posts which leads to poor training in our speciality. More and more students aspire to be gynaeco-logists, but to our dismay we find that less

and less number of resident posts are available for our young postgraduates which leads to student unrest and frustration which explodes to demonstrations. The new craze of the theoretical Rationalisation of medical teaching and patient care is a big tragedy.

The oft repeated conferences on ideal medical education have failed to find a solution. Routine induction of labour by either amniocentesis or by drugs is an act of commission, medico legally it is a vulnerable act which is medically disputable as unnecessary which may lead to harrowing tales of maternal death and its family consequences. Our selection of students is far from ideal. Our undergraduate and postgraduate training programmes are more hypothetical than real due to lack of training facilities, equipments, appliances, available funds for adequate remuneration to all concerned, lack of research funds and facilities and above all constant transfer of guiding luminaries. We are rich in clinical material, amply provided by under nourishment, mal-nutrition, poor sanitation and constant air pollution and sub-standard living conditions.

Indications for operative interference have increased beyond our conventional acceptances. Convenience of patient and physicians has ranked high with various obstetric manoeuvres including "Birth by choice and not by chance".

We have a constant desire to supercede our other colleagues in terms of records and statistical priority. So much so that we nourish and stuff about 4000 medical journals in the world today which contain more half truths and irresponsible observations and deductions. Thus medical publications have reached an astronomical stature of commercialisation with high speed deterioration in the art of present-

ation and publication. Our speciality with all the above concerns is in constant danger of invasion, erosion and disintegration. Many subspeciality organisations have made their assertions. The Stereologists have formed a new organisation called the International Federation of Fertility and Sterility". The physicians interested in pregnancy complications have formulated a new organisation called "Gestosis". Gynaecologists concerned with paediatric and juvenile problems have formed the International Federation of Infantile and Juvenile Gynaecology. The physicians interested in regulating physiology of reproduction have formed an Association of Planned Parenthood, agencies interested in sexual sterilisation have formed International Association of voluntary sterilisation. Diseases of vulva have occupied a place of position resulting into the formation of an International Society for Study of diseases of Vulva. Cancer conscious gynaecologists have formed a world organisation for the prevention of gynaecological cancer. Cytologists have formed an organisation called Association of Genital Cytology studies and we have specialists in geriatric gynaecology, we have an International organisation of Endoscopists called Laparoscopists and now comes the International Association for Clinical research in Human Reproduction. But I must admit that most of the members of all these organisations are actively practising gynaecologists. This means that our Federation should keep constant liaison with these organisations and organise intensive educational training programmes in all parts of the country, preferably with the co-operation of medical colleges. It is far from truth that we shall have Rural Medical Colleges, best equipped in the near future to meet the

demands of local population. Equally, it is true that we shall have no medical Universities in many parts of our country for reasons best known to all of us. However, our Federation can ascertain and establish training cadres and occupy the position compared to either American College of Obstetrics and Gynaecology or British Royal College of Obstetrics and Gynaecology. Further the Federation can organise regularly training programmes for the general practitioners. It has been recognised the world over that medicine is a life long career of education and motivation. This is the only vocation which enjoys the privilege of Faith and affection of the society, in distress, austerity or prosperity.

Now I shall deal with a few problems which concern us directly.

Family Planning, Education and Welfare

The estimated annual rise in population by 70 million people on our planet has staggered the demographers, the politicians, social workers, economists and scientists interested in Human Reproduction where our contribution of population growth is 13 million people annually. The nineteenth century clergyman Thomas Robert Malthus predicted the coming horrors of over population. Sexual urge and human reproduction (our speciality) will out-number all prospects of adequate supply of food, shelter, clothing, medicine and education.

To-day we have 3500 million people on our earth, who will double in 35 years and as a pragmatist I can assure that world population will increase at a stupendous rate of 1000 million every 8 years from the beginning of twenty first century.

It is possible that a child born to-day when he will become 70 years old, he

would form a part of 15000 million people in the world. In six and a half centuries from now on there will be only standing place for all of us if we are reborn. Nature regulated population growth by famine, pestilence and war, but with modern technology in science, the scourges of ravaging diseases are fast disappearing and similarly the efforts of United Nations avert the devastating ills of frequent prolonged and destructive wars between neighbouring countries.

Our population stood at 350 million in 1941 and it stands at 560 million today as per census 1971. Of course this is the population of crippled India after creation of Pakistan and Bangladesh where again 200 million people live. We are expected to reach a target population of 700 million people by 1985 and 1000 million by the turn of the century. The Government of India sanctioned a paltry sum of Rs. 7.5 million in the First Five Year Plan in 1953 and is now spending Rs. 3000 million from the Central Budget to curb the monster of over-population.

The constant question is "Are we really succeeding in our efforts at population control"?

We know that in terms of per capita income in the world of 130 nations we stand at the low serial number 95. Even when compared to the Asian countries, we stand 24 in the serial list of 30 countries with a meagre per capita annual income of Rs. 500 when many nations per capita income averages between Rs. 1500 and Rs. 30000 annually. The average U.S.A. citizen increases his annual earnings by an amount equivalent to the per capita income of a citizen of India.

Last twenty five years have been spent to evolve, preach and practise various methods of dynamic approach to this

waxing problem. From the time The Govt. of India in 1950 called Dr. Abraham Stone to teach us family planning methods, by his most ludicrous method "Rhythm Method and Glass Beed Necklace Formula". We faced food shortage in those years and asked the United States Government to replenish us with food and in exchange we got Stone to advise us on family planning. The decade between 1950 to 1960 was of sporadic attempts at family planning. Even during these years our eminent colleagues like Late Dr. G. M. Phadke and Dr. V. N. Shirodkar insisted on the Government to introduce mass "Sterilisation Programme" to have effective control of population.

The then Government of India wanted to ride the Trojan Horse and was enthusiastic to introduce multi-disciplinary methods of population control. Cafeteria approach was humming the ears of all involved in family planning including talks of crash programmes. The Intra-uterine loop and condom became high favourites. Jack Lippes was invited to come to India in 1965. He visited a large number of family planning centres in India and it appeared a magic wand was invented to curb population growth. Enthusiasm was erratic and programmes were introduced without consulting the specialists. Ambitious targets were prescribed. I.U.C.D. insertions were recorded by lacs, but the enthusiasm proved short lived. The results were disappointing in mass insertion. Caution was voiced at all levels by the obstetricians and gynaecologists and some prominent members of our Federation advised the Government at all levels to go slow with I.U.C.D. programme.

An International Seminar on oral contraceptive was organised by Dr. B. N.

Purandare under the aegis of the Federation of Obstetrics and Gynaecology in 1965. The visiting participants and some of our colleagues advised the Government to introduce Pilot Projects-Pill Programmes at select centres in India. We repeatedly reiterated that the pill programme was cheaper than unplanned programmes and unwanted births. Realising that every day 57000 babies are born in India and knowing that we have a constant population of 120 million couples in reproductive age group who are busy reproducing about 23 million babies in a year and further our demographic gap is fast increasing due to a steep fall in death rate. We know that 5.5 million couples enter reproductive age period annually. The only way to reduce the birth rate from 41 per 1000 to a sizeable reduction meant large scale programmes of sexual sterilisation. Since 1967-68, we are having intensive sterilisation programmes with the help of inducements, incentives and motivation coupled with Population Extension Educative Methods. We have mobile vans, railway station cabins and rural camps to perform large scale male sexual sterilisations and the great Metropolis of Bombay has done a stupendous task in this direction implemented by the Bombay Municipal Corporation when more than 700,000 sexual sterilisations are done in a short period of about eight years.

A large number of Non-Government organisations like Family Planning association of India have executed marvellous programmes in this direction to supplement Government efforts.

The world's largest number of sexual sterilisations are done in India totalling 11 million male sterilisations and 7 million female sterilisations under various schemes of appealing projects with the active co-operation of medical

profession which mainly comprises of Gynaecologists.

In 1965 Shah Committee on abortions was formed by the Government of India and met for the first time in Bombay. The committee submitted a very exhaustive report for the consideration of Lok Sabha. However, it did not make much highway till the title of the programme was changed to "Medical Termination of Pregnancy 1971", which was accepted by Lok Sabha by great applause. The act was implemented on 1st April 1972—Fool's day. Various State Governments approached the problem with great credulity and precision. Government of Maharashtra has to its credit the highest number of pregnancy terminations with involvement of the largest number of certified gynaecologists and suitably equipped institutions. It was estimated that every year 4 million abortions either natural and spontaneous or illegal by quacks, charlatans and unscrupulous medical men are witnessed. The slogan "Every Abortion is a Birth Saved" has not made much highway in terms of quantity. We believe that in the last two years and half a maximum number of pregnancy termination has not exceeded the limit of 300,000 abortions.

The ravages have been reduced, the price structure has collapsed, availability and demands have increased for procuring an abortion.

We as gynaecologists are most concerned with pregnancy terminations and hence we shall be failing in our national obligations if we do not accept this challenge provided by Law. The Indian Penal Code, Section 312 is now obsolete and we are absolved from all legal responsibilities for implementing the M.T.P. Act 1971.

The world population year 1974 was celebrated with all enthusiasm at Bucharest, Rumania and concluded its final session with the slogan "World Population Plan of Action 1975".

We have hardly reached any appreciable results in reducing overall birth-rate. On the contrary there is always a query in the minds of people "which way family planning". Results in urban population deserve recognition, but the achievements in rural India with 570,000 villages are deplorable.

Can we emulate Japan, U.S.S.R. or Republic of China? It is estimated that Japan has done 25 million abortions in last 22 years on official records and an estimated 1/3 more unrecorded. About 30,000 medical men are registered as qualified abortionists. Similarly there is a periodic swing in policy towards abortions in U.S.S.R. for the last half a century. Government encourages and prohibits the same according to changing demands for population needs. In China abortion is legal and with the latest reports available the population rise has been effectively controlled.

The role of barefoot doctors and the Red gate doctors is well appreciated. The role of medical profession specially the obstetricians and our Federation is not recognised. We are conscious of our contribution to mitigate this natural calamity of population explosion. The Federation should demand from all State Governments that it will spearhead its activities by the active participation of its 2000 members. We should demand for recognition of our role as experts with the State Governments and guide them in their family planning programmes. We equally appreciate the role of para medical personnel, social workers, the lawyers, the economists and demographers,

but let them not dictate us what we should do.

Unfortunately, it is not realised that ringing slogans of Nirodh on the All India Radio as the last sleeping dose will not convince the people to practice contraception unless accompanied by population education extension programmes. It is the medical profession which owes the responsibility and accepts the hazards of intra-uterine device and oral contraception.

We try to collaborate with newer technology and computerisation regarding I.U.C.D. impregnated with high dose to low dosage metallic compounds and steroids and similarly mini to micro dose oral pills, long acting steroidal therapy and problems of Auto-Immunisation in relation to control of Human Reproduction.

Endoscopic sterilisation techniques are knocking the doors of all interested gynaecologists. The scientific world is afloat with newer methods of sexual sterilisation with the help of laparoscope, culdoscope, hysteroscope and tubaloscope. We cannot regress from accepting this challenge. Newer mechanical devices from clips to springs are used to block the tubal lumen. Cauterisation of tubes is practised with shocking sequelae many times and sclerosing solutions of all permutations and combinations are passed into the uterine cavity to block the tubal ostia.

We have to formulate the new National Slogans like "Mini Conception Year 1975" or "Maxi Pregnancy Termination Year 1975" to co-ordinate with the United Nations demand for world population plan of action year 1975.

Will it be improper if The Federation was to insist on an All India Legislation to make sexual sterilisation com-

pulsory for all couples who are having more than two children irrespective of cast, creed or customs and further induce the Government of India to apply MISA on all those who oppose or preach against family planning on either religious grounds, ethnic beliefs and social customs and taboos.

Family Education

It has become the need of the family, the State, the community and country if we are to save the nation from the ravages of ignorance and faulty information or prevailing customs. There is no denying the fact that there is an increased incidence of dissatisfaction in marriages, higher incidence of silent suffering leading to psychological disturbances ending into dissolution and divorce, increased incidence of aberrant and unhealthy sexual behaviour, promiscuity leading to increased incidence of venereal diseases, and shocking rise in teen-age pregnancies, especially in innocent school girls. There is a demand from all quarters for the gynaecologist to play his role. Centres are established with various service organisations like Lions, Rotarians and Giants to give advice, information and guidance to those who plan to marry or are married and are in dire necessity for help. This advice saves them the mental trauma and changes their mutual behavioural pattern. It is necessary that every gynaecologist should involve himself in this social service as he is the most conversant with male and female basic anatomy and physiology. Marital counselling and sex education have become essential with the help of family physician, psychotherapist and social worker. I feel confident to advocate that sex education should be extended in the early years of secondary school education so as to avoid many social and

psychological problems. Scientific study of sex should be encouraged. A large number of teenage prodigal problems will be averted with timely available knowledge in relation to sex and will prevent many unplanned or unwanted births. This will finally avoid a large number of loathsome gynaecological problems.

Infertility, a divine curse to the unfortunate couple, is a challenge to modern science. It is estimated that we have a constant population of 10 to 12 million couples who are sterile with an approximate annual addition of half a million. This means a population as big as the population of a continent like Australia is sterile. This is an enormous sick population in a community which suffers mentally, morally and physically for a long span of 30 years on an average.

The couple accepts the diagnosis and submits to frustration and failures. A sterile couple should be received with sympathy and compassion, as we pose to probe and explore the innermost secrets of her life and encourage her to discard and dispel her complex behaviour. This is a tragedy which is more common amongst the affluent and intelligent. In spite of excitement, co-operation, untold sufferings and sacrifices the success rate does not exceed 35%. Ingenious ways and methods are devised with the co-operation of the sterile couple to achieve that final object—assign conception. Infertility becomes a social and psychological problem, more so when declared scientifically that the couple is normal, but unable to conceive, and we are helpless to guide. It is known that on an average 30% of patients visiting gynaecological outdoors or private clinics are sterile and 25% to 35% gynaecological operations are to restore fertility. Here I must accept with gratitude the outstanding and

unique contribution of late Dr. V. N. Shirodkar for his original contribution in tackling the problem of incompetent cervix and blocked tubes. Organ transplants are becoming popular. Human ovarian transplants are experimented with the newer knowledge that there is hardly any rejection phenomena. Fallopian tubes surgery is becoming more complicated to restore physiological patency. Frozen semen banks will be our next legacy for procreation of human species. There is an astronomical rise in anovulation therapy and from exhibition of steroids, gonadotrophins and chemo therapy. We have come to Releasing Hormones, specially L.H.R.H. for successful ovulation and even spermatogenesis.

Dr. Patric Steptoe and R. G. Edwards are quite busy with "Genetic Engineering". They plan to produce "Test Tube Babies" and have successfully carried out fertilisation of human sperm and ovas in vitro. They visualise to help women with irreparable blocked tubes or women with azoospermic husbands. There is a lot of criticism on this issue from all religious, social and medical groups. The question remains "Does humanity desire such pregnancy". The answer is yes when considered individually and no if it is for mass production.

Genital cancer ranks very high in human sufferings. With increasing span of life in India from 22 years to 54 years, the genital cancer problem has assumed great dimensions. Routine periodic check up of breasts and genital organs has become necessary. Cancer detection drives with expanding sphere of activities insist on clinical examination of genitals, digital rectal examination, accessory investigations like improved colposcopic studies, exfoliative cytology, X'Ray examination, infra red

detection, immunological techniques in relation to cancer viruses, thermography and mamography, histopathology studies, needle aspiration biopsy are resorted to as part of routine campaign against genital and breast malignancy.

The United States of America has witnessed an abrupt rise in mammary cancer detection drive, giving advice on teaching methods to palpate the breasts with extensive use of thermography and mamography this year, since the President's wife and the Vice President's wife have undergone radical breast cancer surgery. Planned cancer detection drives in India have also witnessed an increase in the incidence of cervical cancer, corpus cancer and even malignancy of fallopian tubes with an alarming increase in ovarian malignancy. Great strides have been made in the diagnosis and treatment of cancer. Screening and scanning of organs have become routine to judge the prognosis. Extensive radical surgery lasting for hours, well controlled radiation therapy, regular deep X'Ray exposures with high voltage machines and exhibition of newer cytotoxic compounds have achieved much to relieve the cancer patients and prolong their survival.

A good prophylaxis for breast cancer is considered possible when we know that the Canadian Eskimos have the lowest incidence of breast cancer, followed by Japan where prolonged breast feeding is considered essential to prevent breast malignancy. It is advisable to treat all cervical pathological lesions early and effectively to reduce the incidence of cervical cancer.

It is equally true that we have a very few institutions in our country to control this dreaded disease. Poor patients have to wait for weeks for diagnosis and months for treatment. The existing insti-

tutions are over-crowded and over-worked resulting in inefficient treatment. In few years from now genital cancer will be our greatest enemy to face and counter effectively.

Our future energies will be channelised to produce a child's sex at will as demanded and desired by the couple and relatives according to circumstances and national needs, posthumous impregnation, impregnation with the stored frozen semen, procreation without a father by the much publicised "genetic engineering", chemical control of mood, behaviour and character of our patients, genius and virtue of future progeny and prolong life according to ambition to live.

Before I conclude I cite an annotation heard outside the United Nations Lobby.

"When intoxicated with power or prestige a Frenchman will dance, a Spaniard will gamble, a German will sing, an Italian will boast, an Englishman will make speculation, a Pakistani will seek revenge while an Indian will either pray or preach.

In conclusion, I thank the Organisers of this elite gathering and magnificent conference who have ceaselessly worked for the last several months and especially its organising Secretary Dr. Mrs. Padma Rao and thank all of you who have come to Manipal from short and long distances which means hardships and harassments.

I am born this time

I expect to pass from this world

but once

Any good therefore that I can do

Or any kindness that I can show

To my fellow creatures

Let me do it now

Let me not defer or neglect it or fail

By omission

For I shall never pass this way again

JAI HIND