# XXVIII ALL INDIA OBSTETRIC AND GYNAECOLOGICAL CONGRESS HELD AT DURGAPUR 21ST TO 23RD DECEMBER 1984

## Presidential Address

## Learning, unlearning and relearning

by

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Our honoured Chief Guest, immediate past President of the Federation Dr. C. S. Dawn, all our past Presidents who founded and nurtured the Federation bringing it to its present glory, Dr. N. G. Mukherjee, Chairman of the Organising Committee, and his hard working colleagues whose sweat and toil has brought this Congress to reality, distinguished eminent guests, varied participants of the Congress, special invitees, and my delegate colleagues—

We are meeting here under the gloomy shadow of the brutal assassination of our beloved Prime Minister, Mrs. Indira Gandhi. Over the last two decades she not only shaped the destiny of India but also contributed in no small measure to the cause of World Peace and Happiness. It was but natural that the appalling ghastly murder shook the whole world and saddened alike the hearts of millions in India and billions outside. FOGSI joins the entire humanity in praying to the Almighty for Eternal Peace to the soul of our departed leader. Ours is the largest democracy on earth. Our complete commitment to and our absolute faith in democracy has remained unshaken through more than one crisis. And this week we are going to the polls to elect our eighth Parliament. We hope the new government's commitment to health care and population stabilisation is absolute and total.

### Gratitude

Friends, I am indeed very happy and proud to be your President. I am grateful to you for electing me to this high office. My predecessors, all of them without exception, were giants in our profession with remarkable achievements. I have no such pretentions to greatness. But I have complete faith and confidence in your co-operation and help. Armed with these, I hope to conduct the affairs of the Federation creditably. Believe me, the thing I love most is to participate in the activities of the member bodies of the Federation and to meet FOGSI members. Last year, I had the privilege of participating in the various activities conducted by nearly half the members of the Federation. I hope to do better this year. At this stage, I would like to acknowledge my deep gratitude to many who shaped and moulded my professional career. I simply love mathematics. Forty years back when one's choice of profession did

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not go much beyond medicine and engineering, I was expected to take to engineering and was almost pushed into it. It is to my obstinacy that my parents ultimately relented and permitted me to pursue the lengthy and expensive medical studies much against their will. But for their generosity of granting my choice I would not have been a physician at all. Thereafter, it was the joy and happiness of delivering women as a student that prompted me to take to Obstetrics and Gynaecology. Late Dr. P. C. Daruwala and Dr. Juliet DeSaSouza taught me to love and respect my patients and treat them with dedication. Dr. Eustace Sequeira not only gave me an inquisitive mind to conduct medical research but also taught me the fundamentals of medical writing. Dr. K. M. Masani and Dr. C. G. Saraiya revealed to me the pleasures of teaching and writing, and imbibed into me the ethics of medical practice. Dr. B. N. Purandare and late Dr. V. N. Shirodkar exposed me to the art and skill of surgery. Dr. Dina Patel opened the gates of endoscopy and microsurgery to me. Lastly while Dr. Ajit Mehta initiated me in the affairs of Bombay Obstetric and Gynaecological Society, Dr. C. L. Jhaveri painstakingly trained me in the complicated handling of organisational responsibilities. I shall forever remain indebted and grateful to them all.

## Population Stabilisation

### *The Task*

Our great nation has only two ills—one, our evergrowing numbers and two the corruption eroding the very fabric of our society. If by some magic wand we could get rid of these two ills we would be on top of the world. We have now learned to live with the all pervading corruption and we will perhaps take it in our stride. But we will certainly not survive unless we curb our growing numbers. We have a long long way to go to bring down our birth rate to even 25. Zero growth rate is too distant a dream. A growth rate of one is a realistic ambition at present. The job of population stabilisation is not easy. But let us remember that the difficult is possible and the impossible only takes a longer time.

### *Our Contribution*

The involvement of gynaecologists in MCH care and family planning is just natural. No gynaecologist can remain aloof from it even if he wants to. Ideally speaking, spacing should be the backbone of family planning. But an ideal contraceptive—simple, safe, cheap and universally acceptable—is not in sight. Sterilisation is bound to play a crucial role in our programmes, at least till the turn of this century, although spacing methods will assume slowly but certainly increasing importance. More and more sterilisations will have to be carried out year after year. Although vasectomy, being simpler, easier to organise and economical to execute, is theoretically far better than tubectomy for a mass programme, for all practical purposes tubectomy is the central pillar of our programme accounting for 85 per cent of the sterilisations. Male chauvinism, ignorance, tradition and social attitudes all conspire to make tubectomy more acceptable than vesectomy. The crucial role of gynaecologists and hence of FOGSI is obvious.

### *Laparoscopic Sterilisation Camps*

More than half of the female sterilisations are being performed laparoscopically. But if you exclude puerperal sterilisations—which, for all practical purposes,

should be beyond the scope of the laparoscope—laparoscopic sterilisations would account for the substantially great bulk of the remaining, i.e., interval and peria-bortal sterilisations. This wide acceptance of laparoscopic sterilisation in very pleasing to me since way back in 1973, I along with Dr. Dina Patel, initiated laparoscopic camp sterilisations against all odds and despite great resistence from many quarters. But certain undesirable though avoidable developments in laparoscopic camp sterilisations make me feel uneasy. The craze for numbers dictates the affairs from the very top to the very bottom in our sterilisation programme. This is very unfortunate, for this inevitably lays great importance on quantity at the cost of quality. On laparoscopic sterilisation camps this has led to using the laparoscopes without disinfecting them and to performing the operations without due care. The result is unavoidable mortality and morbidity. It is obligatory for the government to eliminate this monster of numbers. The government's action in this direction does not go beyond issuing guidelines regarding laproscopic sterilisation camps. Merely issuing the guidelines without ensuring that they are followed rigidly amounts to actively encouraging the number game to the detriment of women undergoing the operation. The pious guidelines must be enforced rigidly. If the government has the will to make laparoscopic sterilisation camps safe for the acceptors, it should immediately restrict monetary disbursement at such camps to the maximum permissible number of operations as per their own guidelines. While I am urging the government to act effectively, may I request each one of you never to use the laparoscope without adequate disinsfection. Let it not be said of any FOGSI member that he paid no heed to asepsis and disinfection on laparoscopic sterilisation camps.

*Silastic Bands*

An equally disturbing development in the field of laparoscopic sterilisation is the mushrooming of different brands of silastic band without any mandatory quality control. The manufacture and marketing of simple aspirin tablet is governed by many restrictions and rigours of quality control. But an important item of public health and well being viz., the silastic band is free from any such controls. Why? Perhaps we do not know the optimum physical parameters of the silastic band. Perhaps we are not equipped to judge and assess the quality of the silastic band. Perhaps legal position in the matter is not clear. Does silastic band come under the perview of the authorities as a drug? Law is not clear. There may be ample excuses not to act, but the fact that poor quality bands would lead to increased failure rate and destroy the laproscopic sterilisation programme is adequate reason to act—and to act expeditiously and effectively. Where there is a will there is a way. We should insist on biological efficacy as the most important proof of the quality of the bands. On laparoscopic sterilisation camps only those bands should be permitted to be used whose failure rate is convincingly proved to be less than 3 per thousand. Secondly, it should be made obligatory for a silastic band manufacturer to mention at least the dimentions, stretchability and memory of the bands on the packing. If a piece of toffee needs its constituents to be proclaimed on its wrapper, why not the band at least its physical nature? I have studied the physical properties of a variety of silastic bands and find that they differ from each other. Logically, their biological efficacy must also vary and this

could reflect on their failure rates. Silastic bands used on the camps must be the best and not the cheapest. Unless prompt and effective action is taken to curb the menace of numbers and to control the quality of bands, laparoscopic sterilisation programme will prove self-destructive and like the illfated lippes loop programme, the laparoscopic sterilisation programme too would ultimately end as a meteor—bright and luminous one moment and gone the next.

*Duty Exemption*

Another important thing is disturbing our minds. When a double puncture laparoscope can be used as eflectively and as efficiently as a single puncture one, I just cannot understand why only single puncture equipment is duty free. Strange logic, if there be any. On behalf of all the five and half thousand FOGSI members I request the government to make second puncture equipment duty free in the interest of the national family welfare programme.

*Spacing*

Spacing methods are as vital to population stabilisation as surgical sterilisation. It is pleasing to see the revival of intrauterine contraception, thanks to the copper devices. May I ask you to try my technique of stitching an intrauterine device to the uterine fundus at the time of caesarean delivery? This technique gives an expulsion rate of about 5% only. Compare this to the very high expulsion rate of immediate postpartum insertion viz., 20% to 50%. Spacing of pregnancy in women needing caesarean deliveries is very important. And the technique I just mentioned is an effective way of doing it. In the field of hormonal contraception, injectables do have merits and need to be taken more seriously.

*Microsurgical Recanalisation*

Sterilisation—male or female—is the most effective weapon in our fight for population stabilisation. We are urging people to get sterilised with only two children. But the high infant mortality necessitates some of the sterilised people to seek recanalisation. The demand for recanalisation is not insignificant. In fact, it is much more than what one is inclined to feel. It is the moral obligation of the government to provide best possible facilities for microsurgical recanalisation as a part and parcel of the family welfare programme. Every state must develop a few centres for microsurgical recanalisation. This will boost the sterilisation programme and increase its acceptance.

**Continuing Education**

*Modern Practice*

Today's obstetric practice is far different than the one of just a quarter century or so back. Thanks to biophysical and biochemical monitoring of the foetus, ultrasound facilities, amniocentesis, foetoscopy, laboratory skills of prenatal screening, chorion biopsies and progress in neonatal management we can offer excellent service and care to the pregnant woman and her foetus. It is often said that modern gadgets are eroding the clinician's skill and judgement. The reality is far from it. Every good clinician knows that gadgets and laboratory facilities are excellent servants but horrible masters. We are fully aware that gadgets and machines cannot dictate clinical management. They only provide us vital information that we just cannot obtain by using our five senses even when backed by the best clinical experience. To say that modern diagnostic facilities will take away our clinical sense and judgement is as absurd as say-

ing that the advent of diagnostic x-rays made physicians poor clinicians because they no longer diagnose pulmonary disorders by percussion and auscultation alone. In fact, modern day developments have turned a good clinician into a better clinician and a safer one for his patients. On the other hand, a poor clinician tends to place too much faith in the machines and expects too much from them. This is detrimental. It is for us to make good use of the modern day facilities and improve our patient care. Knowledge derived from modern technology must be coupled with the wisdom of clinical assessment experience and expertise. Another common cry is that modern day facilities are expensive and our poor country cannot afford them. In my opinion, any government that cares for the health of its people should strive to give them the best possible in medical care. At least all referal centres must be equiped with the most sophisticated facilities.

If obstetric practice has changed so dynamically, gynecological practice has not lagged benind. It has advanced radically. Many new developments have completely revolutionised the management of patients. Laparoscopy, hysteroscopy, vaginal cytology, colposcopy, radioimmuno assays, ultrasound, microsurgical techniques, *in-vitro* fertilisation, and newer drugs like clomiphene citrate, gonadotrophins, danazol, bromoergocryptine, etc. have all altered patient's care to her great advantage. The world of today's obstetrician and gynaecologist is totally different than that of his predecessor of just a few decades back. He can serve his patients far better and with greater satisfaction.

*Learning—New Skills*

The advent of newer techniques of diagnosis and changing concepts of therapy inevitably implies the need to acquire new skills and fresh knowledge. Besides, medicine is expanding by leaps and bonds. New information is pouring in every day. A part of what we learnt as medical students is fast becoming obsolete. A physician of today must keep pace with new developments and rapidly altering modes of patient management. To achieve this one must read journals and new books. How many of us have time and inclination to do this? All of us must do this anyway. I would most earnestly appeal to you to spare at least one hour every day in scanning new medical literature. This by itself is not enough. It is necessary to grab every opportunity to attend conferences like our present congress, clinical meetings, guest lectures, symposia, panel discussions, etc. It is an important function of all memberbodies of FOGSI to arrange such programmes as often as possible for benefitting their members. I promise all possible help from FOGSI to its memberbodies to enable them arrange academic programmes. Memberbodies should vie with one another in organising conferences, continuity of education programmes and mass education activities. In the final analysis, the continuity of education programmes are intended to improve patient care in all directions. It is, therefore, equally important to pass on relevant new medical knowledge to family physicians. Better patient care will go a long way, if participation of family physicians in the educational programmes arranged by memberbodies is encouraged and ensured. Memberbodies could also distribute a monthly bulletin or newsletter to all their members conveying to them salient new information appearing in medical journals. Such publications can be made financially viable and be made to reach beyond the mem-

bers of the memberbodies, viz., to the family physicians by judiciously including advertisements in them.

Learning new skills is not always easy. It needs determination, diligence and devotion. If you possess the will opportunities would not be difficult to find. In fact, our member societies offer such opportunities to their members. Age should not be a deterent to learning. Ignore the saying—"You cannot teach new tricks to old dogs". But remember, learning is an active process and needs efforts.

*Unlearning—Outmoded Practices*

All our therapies are based on preveling concepts. Some of them are based on sound foundations and continue to be employed until new research alters the very fundamentals on which they rest. But there are therapies which have entered our practice either on flimsy grounds or for want of anything better. These therapies have to give way to better modalities very quickly. Thus some methods of treatment are like ladies fashions, popular today discarded tomorrow. This invariably means that we have to unlearn many things as time passes. But, if it is difficult to learn, it is more difficult to unlearn. Customs and habits die hard. Primary ventrisuspension performed on a mobile retroverted uterus in the absence of any pelvic pathology was an accepted procedure in my student days. Today, it is established that it does no good to the patient; in fact, it inflicts the mortality, mobidity and complications of laparotomy on her without any compensatory benefits. And yet, it is still practiced by some who refuse to unlearn. Similarly, many a cervical erosions are still being cauterised needlessly. Treatment of threatened abortion by unwarranted hormones, vitamins and tocolytic drugs can, by and large, be considered outmoded. But these still continue to be prescribed without purpose. Unlearning needs great determination and courage. But we must unlearn in the interest of our patients.

*Relearning—Wisdom*

We also have to relearn things when necessary. The practice of breast feeding is a classical example. Universally practiced through human history it was neglected and relegated to second place for about 50 years preceeding 1970. During the last 15 years or so, obstetricians and paediatricians have radically changed their concepts about feeding a new born baby. The menace of bottle feeding has been brought to light. It is now fully realised that diarrhoea, malnutrition, repeated infections and infant deaths are often the sequelae of bottle feeding. UNICEF experts feel that bottle fed babies are 3-5 times more likely to die in infancy than breast fed ones. It is estimated that bottle feeding causes ill health to more than 10 million infants every year. Complete elimination of bottle feeding by itself could bring down infant mortality significantly. Advantages of breast feeding go far beyond giving the baby most convenient and perfect instant food fortified with antibodies to fight infection. It provides the most lovable physical and emotional experience for both the mother and the child cementing a permanent bond between them. Add to this the tremendous advantages of natural contraceptive effect accruing from breast feeding. Lactation is the most important contraceptive method in the world since breast feeding is giving 34.7 million couple years of protection as against only 24 million couple years provided by all the family planning programmes put together. It is estimated that 5 million

births could be avoided every year in our country if breast feeding is universally and effectively practiced. We, as obstetricians, have to play the most crucial role in promoting breast feeding. Adequate counselling in the antenatal period must be followed by initiation of bresst feeding within an hour of delivery and insistence on exclusive breast feeding. Education of the nursing staff working under us is often necessary. The obstetrician's role in restoring universal breast feeding and eradicating the catastrophy of bottle feeding is vital and indispensable. By offering to our patients proper guidance and advice and insisting on exclusive breast feeding we will reduce infant mortality significantly and avoid many unwanted pregnancies. We are re-learning the wisdom of breast feeding.

**Medical Education**

In the field of medical education there is much to be desired. Admissions are not always on merits. It was amusing to read that in a certain state, ridiculously huge number of marks—many times more than those scored by the candidates—had to be given as grace marks to enable requisite number of students fill up the seats in the medical colleges! The teaching is specialisation oriented rather than geared to produce much needed family physicians. The conducting of examinations is not beyond questioning. The present examination oriented learning may shift to knowledge oriented one if semester system is introduced wherein, examinations could be held every three months and the student required to appear for at least one subject every time. It is not difficult to reorganise the teaching programme to suit the semester system. The present examinations test the memory of the candidates rather than their knowledge. Semester system and greater emphasis on multiple choice type questions would make the examinations knowledge oriented.

Post Graduate education is far from satisfactory. In my opinion, at least three years residency training in obstetrics, gynaecology and allied subjects is a minimum that should be prescribed as a mandatory requirement before one can appear for a doctor's of master's degree. In many universities, including mine, far too many students are admitted for post graduate training than can be adequately trained. Every student admitted for postgraduate studies must on admission be assured of three years continuous residency training. This is possible only by increasing facilities for residency training.

**Indian College of Obstetricians and Gynaecologists**

The standard of postgraduate education varies widely not only from state to state or from university to university, but also from college to college. This is ridiculous. To improve the standard of specialists in the profession and to make it uniform is precisely the purpose for which the Indian College of Obstetricians and Gynaecologists is founded today. The College would initially hold all India examinations of a uniformly high standard and in due course would hopefully provide training facilities of a very high calibre. FOGSI members should be very proud of their own college. The need for a college has been felt and debated for many years. At last the college has come into existence. It will need herculean efforts to nurse the college during its formative years and to build it into the best and the most effective academic institution in the field of our speciality. Fortunately, we have the expertise to do so. With your unflinching

support and dedication the college will achieve its goal speedily.

**Health For All by 2000AD**

This is our goal. FOGSI members can contribute their mite, which is really tremendous, to the national efforts of striving to achieve this. Excellent MCH care and due emphasis on immunisation of the mother during pregnancy and of the new born during the first few months should be the obstetrician's responsibility. Tetanus should be considered an eradicable disease. Immunisation against tetanus during pregnancy must be considered obligatory. Rh-isoimmunisation is largely a preventable entity. It is solely the obstetrician's responsibility to prevent Rh-isoimmunisation resulting from pregnancy. Administration of anti-D to Rh-negative women at spontaneous abortion and pregnancy termination is a must. Immunisation during the first few months of life will go a long way in preventing infant mortality and making small family norm readily acceptable.

**FOGSI**

*Membership*

From a small humble beginning FOGSI has grown into a large family of over 80 memberbodies and 5,500 members. We are one of the largest medical professional body in the country. Yet there is tremendous scope for expanding our membership. FOGSI need not practice birth control. Too many of our colleagues are still outside the fold of our memberbodies. Let us make them our members and involve them in FOGSI activities. Secondly, it is necessary for FOGSI members to take greater interest in FOGSI. The attendance of members in progammes organised by member bodies and by FOGSI should be much better. When questionaires are sent they draw a poor response. Why such an apathy? May I request you to participate in FOGSI activities with keen interest and play a positive role?

*Education of the Public*

FOGSI members can play an important role in mass education. Sex education, infertility, contraception, pregnancy, child birth, cancer detection are just some of the areas in which mass education programmes by FOGSI members would be of immense benefit to the society. It is my suggestion that every academic meeting or conference organised by us should be linked with a mass education programme like an exhibition, lecture series, brain trust etc.

*FOGSI Building*

FOGSI activities are constantly on the increase. The various subcommittees of FOGSI are continuously expanding their programmes. The work involved in editing, printing and publishing our journal is becoming more and more demanding year after year. Incidentally, our journal is getting a face lift. In 1985 it will come to you with a more attractive cover. I am sure you will like and appreciate this new look of the journal. The starting of the Indian College of Obstetricians and Gynaecologists also means a flood of workload. All this has made it very necessary for FOGSI to have much larger premises to efficiently conduct its multifarious activities. It is hoped that FOGSI will soon have its own building with the active help and close co-operation from all its members and memberbodies.

**1985**

Friends, we are on the threshold of 1985. Let us resolve to improve our professional abilities by learning, unlearning and relearning, to take greater and greater interest in the activities of FOGSI and its member bodies, to lay down a solid foundation for the Indian College of Obstetricians and Gynaecologists and to contribute our voluntary services freely to achieve the challenging national goals of population stabilisation and health for all by 2000 AD.

Jai Hind