BRITISH MEDICAL JOURNAL

LONDON SATURDAY AUGUST 1 1959

THE OCCASIONAL OBSTETRICIAN*

BY

A. M. CLAYE, M.D., F.R.C.S., F.R.C.O.G.

Professor of Obstetrics and Gynaecology, University of Leeds

I am grateful to the British Medical Association for suggesting to me an alliterative title for a subject which is decidedly topical. I love my love with an O because of its Obstetrics—some people find it objectionable or even odious, which I consider odd. A distinguished doctor who discussed the subject in my presence rather frivolously suggested it might be obscure, obscene, or even obsolete. Was he perhaps thinking of a "Brave New World"? I think, myself, he was obsessed with O.B. Surely for interest it is outstanding and overshadows all else in medicine.

I am proud to have been asked to speak in a district within the sphere of influence of the South-West of England Faculty of the College of General Practitioners. I have read more than once with great benefit and enjoyment their obstetric survey. As I did not wish for the purpose of this talk to be biased by the Cranbrook report, I took the precaution of putting it together before the publication of that document, and at the moment of writing I knew very little of what it was likely to recommend. But I have now read it, and so I am inserting at appropriate points the comment of the report on any particular subject after my own. It is my belief that the obstetric service of this country would be better if the general practitioner played a greater part in it. He does so to a greater extent in this area than in my home city of Leeds, where 70% of the births take place in specialist hospitals. The writer of the introduction to the survey states, with some justification, that "it is not to be expected that the specialist who sees most of the failures and few of the successes will have a balanced outlook on general practitioner obstetrics." However, many of my relations are, or have been, general practitioners, and I have had instruction calculated to help the balance of my outlook.

It is no good practising obstetrics unless you do a fair amount of it. If I may be allowed to utter a shameless platitude, the man who does a good deal is likely to do it better than the man who does only a little. He will get more experience in the necessary manœuvres, and more of the thrills which attract me to it. I quote Nixon and Hickson: "The virtual abolition of the private maternity case has led to fewer cases being attended during labour by general practitioners. This is a retrograde step. To realize when something is going wrong, it is necessary to have seen a large number going right." In the survey there were about 30 deliveries under the care of each doctor during the year; and 48% of all deliveries, or nearly 15 of the 30, were attended by the doctor. One or more visits were paid

by the doctor during labour, but not necessarily for delivery, in an additional proportion of cases, varying in the different classes (primiparae and multiparae, home, G.P. hospital, and nursing-home deliveries) from 4 to 20%.

This average of 30 a year seems to me more than occasional and gives adequate experience—more, indeed, than that of their midwife colleagues (I quote) "employed by county authorities, many of them, working in rural areas, who average only about 20 cases per annum."

The General-Practitioner Aspect

The Royal College of Midwives has expressed its views on what it expects of general practitioners. In its evidence to the Committee on General Practice under the Health Service in 1951 it stated: "General practitioners undertaking maternity medical services should have recognized obstetric experience." In its evidence to the Cranbrook Committee, kindly provided for me by Miss Mary Williams, its president, a little more is said. "Midwives did know from their own experience that they could have confidence and expect real co-operation from doctors who had held postgraduate hospital appointments or obtained postgraduate qualifications, and from other men who, though they might not have the qualifications, had done a great deal of domiciliary midwifery over the years, and had acquired a high degree of experience and skill."

The Royal College of Obstetricians and Gynaecologists, I find, is often mistakenly supposed to be the enemy of the general practitioner in obstetrics. This I think may be based on the statement in the College 1954 report on the obstetric service about the obstetric lists. It reads: "There must be some form of selection based upon a greater practical experience than can be provided in the undergraduate curriculum, and all entrants to the obstetric list should have held a six-months' resident obstetric appointment after qualification." Paragraphs 349 to 352 of the Cranbrook report run:

349. The practice of obstetrics requires special skill and experience. There is not enough domiciliary maternity work available to enable every general practitioner to obtain and maintain the necessary standard of skill. (Paragraph 192.)

350. The obstetric list should be continued. More uniform criteria should be applied for admission to and retention on it. (Paragraphs 193 to 197.)

351. A six months' resident appointment in an obstetric unit under the control of a consultant obstetrician should be the normal criterion for admission to the obstetric list. (Paragraph 195.)

*A B.M.A. Lecture given to the Trowbridge Division on April 23, 1959

352. In order to remain on the obstetric list, which should be reviewed every three years, a doctor should, over the preceding period of three years, have had at least 60 complete booked cases, of which he should have attended deliveries of at least half. (Paragraph 196.)

Unquestionably if the conditions for the list were tightened up, the stricter conditions should apply only to new entrants. Paragraph 201 of the Cranbrook report stated: "The present obstetric list should be accepted as it stands. . . . G.P.O.s should fulfil the criteria for remaining on the list at the first review, which we recommend should occur at the end of three years." The College report already cited also stated: "Beds for uncomplicated cases should be provided in general practitioner hospitals or homes in close integration with the main obstetric units." One of our important general principles has always been that the doctor responsible for the antenatal care must also be responsible for the labour. In our evidence to the Willink Committee we stated: "It is anticipated that the total number of institutional births might increase to 90% (that is, from the present 65%). . . . It is probable that this increase will be mainly in general practitioner beds . . . staffed by general practitioner obstetricians." Cranbrook report paragraph 258 remarked: "The extra beds required to enable the hospital confinement rate to be raised to the suggested average of 70% of all confinements should where possible be general practitioner beds."

The doctor who makes the minimum number of examinations, two antenatal and one post-natal, needed to qualify for the fee for maternity services, is certainly an occasional obstetrician. But in mentioning this I know that I am flogging a dead horse. Nearly two-thirds of all the patients dealt with in the survey were examined seven or more times. What its writer described as textbook antenatal care involves a dozen examinations, if the patient books at about 10 weeks. The frequent examinations in the later weeks are based largely on the necessity for making the diagnosis early if pre-eclampsia develops, for if it is so diagnosed it seldom becomes serious. Paragraph 211 of the Cranbrook report begins: "We consider that it is unnecessary for us to define precisely the content of antenatal care, but we agree that only two antenatal examinations by a doctor are inadequate." One of the ways in which the obstetric patient often suffers is by falling into the hands of too many authorities. She may indeed suffer more in this way if she is being confined in a specialist hospital. But if she is in the hands of her own doctor, the midwife too is expected by her Board to make antenatal examinations.

The notices concerning a midwife's code of practice in the handbook incorporating the rules state that "when engaged to attend a confinement a midwife must . . . carry out such examinations of the patients as are necessary, or see that they are carried out." It is very desirable that the patient should not be badgered. When possible—and I know that because of the nature of midwifery this is sometimes difficult—the midwife should attend the doctor's examination, and make hers on that occasion. This enables the two of them to consult, and facilitates their speaking with one voice, which does not always happen when the examinations are made on separate occasions by doctor and midwife. In the last two sentences in paragraph 211 of the Cranbrook report we find: "We think that it is

impracticable to recommend that the general practitioner obstetrician and the midwife should always see the patient together, but consider that there should be the closest co-operation between them. We suggest that antenatal examinations should not normally be given in the ordinary surgery session."

Our Set Ways

The occasional obstetrician is a good deal less likely to be up to date in his methods than the man who has a sizable obstetric practice. I cannot imagine that one who spends only a minute fraction of his time on practical obstetrics will think it worth while to allot further time for reading about the subject or attending discussions or addresses. So he may be unaware of the extensive use of episiotomy with forceps delivery or without it, of local analgesia for forceps delivery, breech delivery, and repair of the perineum, and of the use of ergometrine during delivery of the child, and so on.

We are all of us conservative, and change our set ways with reluctance. The specialist is less conservative than the family doctor, who I believe in his turn is less conservative than the midwife. I do not find this surprising for it is natural that new methods should be tried out first in hospital, and come to be used in general practice when they are established. The process of filtering through sometimes takes rather a long time. Consider episiotomy. When used before forceps delivery it is described in the survey as a "relatively recent innovation." What that means depends on relatively to what. I was a resident officer in obstetrics in 1926-7-8, and at that time used it whenever extracting the head with the occiput behind, and occasionally with the occiput in front if tearing seemed inevitable; also for all primiparous breech deliveries. But it was not new then. Still less is it new now, though it is used more extensively than heretofore. In my view my registrars and house officers tend to do it too often. No doubt I am becoming conservative or old-fashioned myself.

Very few forceps deliveries in hospital escape episiotomy nowadays, though it is possible to deliver many primigravidae without it, without laceration, and without condemning them to subsequent prolapse. Many second stages are rightly shortened by episiotomy when the head is low, without the need for forceps delivery, and the risk of the premature baby's suffering intracranial haemorrhage is reduced by the performance of the operation. But you should not have to use this last indication often, for when the patient goes into premature labour before 36 weeks her baby's chances will be best if she is delivered where there are special facilities for prematures. As the Cranbrook report paragraph 238 says, "We consider it most important that a mother in premature labour should if practicable be transferred before delivery to hospital which has a premature baby nursery."

One of my informants about general practice tells me that obstetrics is "one of the easiest branches" of such practice. There is difference of opinion about this, and it depends a good deal on what is meant by easy. Attendance at delivery is certain to involve some night work, which is not "easy" in one sense of the word. I know I am not alone in thinking that the responsibility for a normal case almost-invariably involves anxiety for the obstetrician at one or more moments between the

booking early in pregnancy and the conclusion of the case after the post-natal examination. Anxiety is un-easy. And surely the ease depends to a very great extent on the amount of experience one gets.

A Joint Responsibility

From what I have already said you may have gathered that I think the doctor should be present when the patient is delivered. When I was in private practice I always tried to see my patients at least once in the early part of labour, and to be present at delivery. With occasional exceptions I used to deliver the patient myself. I have the feeling that the doctor ought to be able to deliver the baby normally at least as well as the midwives with whom he works, and this needs practice. On the other hand, it is more important for him to be present than to conduct the delivery, and he can sometimes be usefully employed giving an anaesthetic. I am going to mention local analgesia in a moment. The first three sentences of paragraph 212 of the report run like this: "We are of the opinion that a general practitioner should, whenever possible, attend all domiciliary confinements, to safeguard the mother and the baby against unforeseen emergencies, to give the patient confidence, and incidentally to maintain his experience. Ideally, he should visit early in labour and then be present for the delivery. The conduct of a normal confinement is the joint responsibility of the doctor and midwife."

The birth of the baby is the climax to which the many months of pregnancy lead up. It is proper—indeed there are doctors who find it a thrill—that the man who has prepared the patient for the event should be there when it takes place. I appreciate that a phenomenon such as an influenza epidemic may well prevent the doctor being present.

Techniques

May I say a word or two about the techniques needed in normal and near normal obstetrics? I have already mentioned episiotomy. To use this operation it is also needful to be able to give local analgesia; and for low forceps delivery, another necessary technique for the general practitioner obstetrician, to do a pudendal block. "Difficult" is another of these words with no absolute meaning, but I would not use it about local infiltration of the perineum or about pudendal block. The main reason why they are not more used in general practice is the conservatism to which I have previously alluded. However, more doctors to whom the techniques are familiar are going into practice each year, and no doubt they will be more and more used. The important points in their favour, you will remember, are: (1) they have no adverse effect on uterine action; (2) they have no adverse effect on the establishment of the baby's respiration; and (3) they make an anaesthetist unnecessary.

The carrying out of the usual medio-lateral episiotomy is easy, though it is often done incorrectly. Its repair, however, is another matter. I can compare it with another operative procedure that I frequently carry out—namely, posterior colpoperineorrhaphy for rectocele. The repair of an episiotomy is in my view a slightly more difficult operation than that. The reason for this is that when the episiotomy incision has been made, the muscles divided pull on the two sides of it unevenly. It needs some care, therefore, to bring corresponding

points on each side of the incision together, and to obliterate all dead space, so that the parts come together as nearly as possible as they were before the incision was made.

The incidence of low forceps delivery has greatly increased in recent years. It is being realized more and more that a long second stage may be harmful by stretching unduly the soft parts at the outlet. It is recognized, too, that it is safer for the baby to be born before it has experienced distress, rather than after that has occurred. It is likely that the incidence of forceps delivery given in the South-west Survey—15.4% of primiparae, and 3.4% of multiparae in doctors' confinements—is lower than the ideal. Apropos of what I have just been saying, the survey states—and I do want to stress this—that where "attendance at the confinement has been delegated to midwives, forceps delivery was relatively uncommon; but when it became necessary, a long second stage was more frequent and more babies were lost." Sometimes, though the head is visible, it is not the bony skull that is low, but the caput succedaneum which is large. Such a case is more difficult to deal with, and it is important that it should be recognized. The doctor can then either deal with it himself, if he feels able to do so, or obtain expert help.

By the way, there may be some who think that an average of 20 cases a year is too large to insist on. But consider the implications relating to forceps delivery. If your forceps rate is 20%, which is probably a reasonable figure, you will apply forceps four times a year. I do not think it can justly be said that this amount of practice is excessive. The implication relating to total deliveries is that the doctor will have the opportunity of attending one every 18 days. This also does not strike me as excessive.

You may take the view that it is a misuse of the word "occasional" to apply the term to an obstetrician who will not take obstetric emergencies, will not apply forceps, do a breech delivery or a manual removal. It can be said of such a man that he selects the occasions on which he is prepared to undertake obstetrics, and so is occasional in that sense. This was the position of some of the deputies in the survey. I need hardly say that if the patient is liable to fall into the hands of someone who will not do this, that, or the other manoeuvre which may prove necessary, and she knows it, she is not likely to be full of confidence about the event. If she does not know it, and such a deputy is called, an unfortunate situation develops at a time when she thought all was arranged and tidy.

Manual Removal and Breech Delivery

Manual removal is the procedure which figures at the top of the list relating to deputies: 14% of doctors had no deputy for manual removal. Now manual removal is a simple procedure, much simpler than the average low forceps delivery. The taboo on it is a survival of the days when it carried a maternal mortality of 2%. The main reason for this was that in those days, from fear of infection, it was often delayed until the patient was collapsed, and the operation killed her. When it is done on a patient in good condition it is a very safe procedure.

Breech delivery is another matter, and the results vary very much from person to person. I well remember in my own hospital some years ago when

we had two registrars at the same time who had not the knack of it. The first consideration is to prevent it happening by doing external cephalic version. The next point is to refer to a specialist the few patients in whom turning cannot be achieved, if the doctor does not wish to undertake the breech delivery. That leaves those in whom the diagnosis is not made before labour. There is still a chance that the condition may be diagnosed early in labour, so that if it is desired the patient may be transferred to a specialist hospital. If it is not diagnosed until delivery is starting, the doctor will have to deal with it himself, so that he should have some idea of what Tristram Shandy called "the plain principles of the business." The higher the proportion of successful external cephalic versions the less the experience in breech delivery. And, I should say, a very good thing too. The evidence is that breech delivery is no less dangerous in a multipara than in a primigravida.

Conclusion

I am afraid that I have not kept strictly to my subject throughout. This is probably the result of browsing in *Tristram Shandy*, which sets a shocking example in the matter of digression.

There are at least two types of experience in life, one of which it is more blessed to have occasionally. If I lived in the Lake District, and when I looked out of the window in the morning and could see on every clear day Helvellyn and Catchedicam, I might well soon become unconscious of their presence. But when I see them once a year or less, I get a fresh thrill every time. If I could follow the example of Horatio Bottomley and drink champagne every day for lunch, its fascination might well soon pall. As Shakespeare put it:

So am I as the rich, whose blessed key
Can bring him to his sweet up-locked treasure,
The which he will not every hour survey,
For blunting the fine point of seldom pleasure.

But for experiences that demand technique, like playing bridge or lawn tennis, or practising surgery or obstetrics, practise tends to make perfect or at any rate better, and gives one a sense of pride in achievement.

BIBLIOGRAPHY

- An Obstetric Survey by the South-west of England Faculty of the College of General Practitioners. Torquay, 1957. Supplement to *Research News Letter*, No. 14.
Report of the Maternity Services Committee, 1959. London.
Report on a National Maternity Service. Royal College of Obstetricians and Gynaecologists. 1944.
Report on the Obstetric Service under the National Health Service. Royal College of Obstetricians and Gynaecologists. 1954.
Memorandum from the Royal College of Obstetricians and Gynaecologists submitted to the Maternity Services Committee of the Ministry of Health, supplementing the above Report.
Nixon, W. C. W., and Hickson, E. B., *A Guide to Obstetrics in General Practice*, p. 280, 1953. Staples Press, London.
Redman, T., *Brit. med. J.*, 1950, 1, 814.

British Instruments, a directory and buyers' guide for 1959, is published by the Scientific Instrument Manufacturers' Association and the United Science Press Ltd., 9, Gough Square, London, E.C.4 (615 pp., 42s). It covers scientific and industrial instrumentation for research and production in a wide variety of subjects, and includes glossaries in French, German, and Spanish.

TREATMENT OF TETANUS NEONATORUM WITH INTERMITTENT POSITIVE-PRESSURE RESPIRATION

BY

P. M. SMYTHE, M.B., M.R.C.P.

AND

A. BULL, M.B., F.F.A.R.C.S., D.A.

*From the Departments of Paediatrics and Anaesthetics,
University of Capetown, and Groote Schuur Hospital,
Capetown*

Tetanus neonatorum has always carried a high mortality. In the past six years 40 cases have been admitted to Groote Schuur Hospital and only one survived. Many of these infants appeared to die of respiratory failure because, by giving intragastric oxygen, life could at times be prolonged for up to 24 hours after breathing had ceased. This fact, coupled with the successful treatment of tetanus in older patients with intermittent positive-pressure respiration (I.P.P.R.), inevitably led us to consider the application of I.P.P.R. to these infants. The only model of the Radcliffe pump (Russell and Schuster, 1953; Smith *et al.*, 1954) available to us is not, however, designed to deliver the small tidal volumes encountered in neonates. The youngest child treated with I.P.P.R. recorded in the literature (Lawes and Harries, 1956) was aged 10 months and died with surgical emphysema of the lung and a pneumoperitoneum. In this paper is described a simple modification of the Radcliffe pump and its application to the first nine cases of tetanus neonatorum to be treated with I.P.P.R.

The two defects in the standard Radcliffe pump and Stott valve mechanism when applied to infants are the high percentage of the tidal volume which is constituted by the dead space lying between the valve and the patient, and the inefficient activation of the Stott valve by the small expiratory volume of the infant. These defects were overcome (Fig. 1) by increasing artificially

FIG. 1.—Photograph of Case 8 while on intramuscular curare, showing how the Radcliffe respirator was adapted for use in infants. The rubber tube connected with the Y-piece is joined to the manometer.

the tidal volume on the patient's side of the valve. To do this a rubber bag of some 300-ml. capacity (a B.L.B. bag proved satisfactory) was attached to the larger opening of the delivery arm. To the narrower side-arm