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An Obstetrician's Reflections

– Invited Editorial –

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When I graduated as a physician in 1950, I decided to specialize in obstetrics. What was then the situation in our country in that respect? The two main schools of obstetrics in the world were represented in our School of Medicine. The German and the Viennese school, by Professor Josué Berutti, and the French school, based on the concepts of Kreiss in Strassburg, by Professor Alberto Peralta Ramos. I had attended both courses as a graduate student and they had a profound influence on my choice. At that moment, Kreiss' concept of medical delivery – that is, the administration of sedatives and antispasmodic agents in all cases and the premature rupture of the membranes – was in fashion, while Peralta Ramos had brought back from France directed childbirth as advocated by Voron and Pigeaud. The pain of delivery had to be "alleviated" and this made labor shorter. A Brazilian obstetrician, Magalahes, stated that "a woman must never hear the cock crow at more than one dawn", by which he meant that no delivery should last more than 24 hours. As a consequence of this criteria, natural delivery was replaced by one that was strictly controlled and with constant medication. Children were usually born sedated and obstetricians had to reanimate them using techniques that were not altogether harmless.

But at that time post-war technology began to be applied to medicine. In the field of obstetrics, it began with the acoustic effect with Doppler, which gave rise to ultrasound and drove Pinard's stethoscope away from the pregnant woman's abdomen and from the prenatal consulting rooms. The physician, therefore, was also driven away from the pregnant woman's abdomen and left only with palpation and vaginal touch to make direct conctact, as the apparatuses transmitted the fetal heartbeats. With echography, too, it became possible to see the baby outside the pregnant woman's abdomen as if it belonged not only to her but also to those observing it. A pregnant woman could see her child whole but outside her body, and this drove the physician even farther away from her.

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But let us go back to 1950. It was the heyday of antibiotics in the treatment of puerperal infection. They replaced the trementine-induced abscesses, designed to lower temperature and permit access to septic foci. There were then separate wards for infected patients, who were thus forced into isolation. The disappearance of – or at least the decrease in – the incidence of puerperal infection emptied these isolated wards in the old maternities and shelters for unmarried mothers were created there. These women were easily distinguished because they had to wear special uniforms and they were isolated because they were disgraceful. As they usually stayed in the hospital for several months after childbirth, until they could get a job which allowed them to keep their children with them, they soon were made pregnant again by the cleaning personnel.

These astounding measures were modified in the course of time and isolation wards became private or were devoted to research into obstetric physiology, which was emerging then thanks to the efforts of the Uruguayan school, headed by Alvarez and Caldeyro Barcia.

As may be seen, from being obstetricians we turned into researchers on behalf of Argentine obstetrics.

Echography and ultrasound were later on added to by fetus monitoring, the study of fetal movements and the DIPS. Research into obstetric physiology contributed to these advances, and obstetricians became fetologists as we gradually invaded the uterus cavity and thus got in touch with amniotic fluid, and also learnt how to measure and study it.

When I started my graduate studies in obstetrics, my first teacher was Alfredo Guiroy, one of the most outstanding disciples of Professor Peralta Ramos. He advised us to assist first a hundred normal deliveries and, after that, to assist the first hundred forceps deliveries and, then to perform the first hundred cesarean operations. In 1950, these operations were only performed by physicians with experience in surgery, who were few. It was the time when the vaginal way prevailed, as well as juggling with the high forceps and resorting to cervix sections when dilation was insufficient. There were no medical internships and I "created" mine by being on three weekly 24-hour shifts at the Maternity of Hospital Rivadavia and a fourth one in the outskirts of Buenos Aires. In that way I was able to carry out my teacher's advice, and I remember that in 1953, when I met Professor Nicanor Palacios Costa, he asked me about my previous experience and then said: "I haven't yet performed by 100th cesarean section". It was risk surgery at that time, a fact that seems to be ignored now, when it is indicated much too often, no doubt because they usually make things easier for the obstetrician and imply higher fees.

But, how were deliveries assisted at that time? In 1950, only two types of sedatives were known: Spasmalgine, Buscapina and similar ones, which had a basic sedative cortical effect and, secondarily, were antispasmodic agents, and the oxytocins – derivates of the thymus and the hypophysis having a stimulating effect on the uterine muscle but without the effectiveness of Du Vigneaud's oxytocin synthesis in 1958.

These drugs were administered intramuscularly and their effect on the uterine muscle and on the fetus was unpredictable. When oxytocine was synthesized

in 1960, it was first administered intravenously on a drip, while research work carried out by the Uruguayan school of Alvarez and Caldeyro Barcia, and Hohn in the United States, set the guidelines for further research into obstetric physiology. Now deliveries came closer to physiology and obstetricians felt we were being less iatrogenic.

But this led to an excessive use of medication and, with deliveries being always directed, the spontaneity of natural delivery and the respect for nature are lost. If we think that the obstetrician's only contact with the pregnant woman is through the new technology and that, at the same time, he medicates in excess, we will realize the physican has become a mere practised expert, far removed from the tender, supporting human being the pregnant woman needs and, therefore, the doctor-patient relationship is lost.

At the same time, the team of trained people with different roles – midwife, nurse, anesthesiologist, neonatologist – also dilute that relationship in their attempt to improve it. They all play their roles efficiently but none is the direct and affectionate spokesman the pregnant woman needs at this culminating moment of her womanhood.

Even though the obstetrician retains the leadership, his responsibility is diluted and he is driven away from the pregnant woman. But when a pregnant woman must choose her obstetrician, she seeks a human being and, as she cannot find him, she accepts a name on a health system brochure. It is only a name and not a man that she finds.

We have always been aware of the fundamental importance of the pregnant woman's first interview with "her obstetrician". She tells him not only about her worries over her gestant abdomen but also about her concerns as a woman who is going through a life crisis: pregnancy. Her pregnancy is the converging point of all the anxieties she has ever had and which have increased in the course of her life, anxieties she has never been able to clarify. That is why the physician who asks questions before he examines the patient is, as von Weizsäcker said, a good physician, while if he only examines the patient, he is a bad physician.

Fedor-Freybergh pointed out there are two kinds of physicians: psychosomatic doctors and bad doctors, perhaps in this speciality more than in any other.

The value of the first interview lies in the early detection of any possible pathology the pregnant woman presents or may present in the future. Pregnancy as a "stress" and overload factor may lead to toxemia or high blood pressure or diabetes, etc.

Early, adequate, and thorough prenatal control is very important, too, because it is often the first medical checkup in the pregnant woman's whole life, if there have not been intervening illnesses in her childhood and adolescence. Ideally, this examination should be carried out before gestation.

When a pregnant woman meets an intelligent obstetrician, a symbolic bond is established that will last until 45 days after the delivery. Such good communication and the doctor's ability to look at and listen to her is the only basis for the success of a normal pregnancy and the early detection of pathology. Laboratory tests and other tools like monitoring, echography, etc., supplement that human relationship but do not replace it.

Each further interview is arranged on the pretext of controlling the evolution of pregnancy but the truth is it strengthens the affective bond between the physician and the pregnant woman.

Besides, the physician who is going to assist the delivery should provide the gestant woman with the basic elements of her preparation. If he is not trained to do it or does not have time, he should refer her to members of his team: obstetrician, psychologist, kinesiologist, or doula, someone who is going to be with her during the delivery. Respect for the pregnant woman and her respect for her doctor are basic here.

We must never be categorical as to the delivery date, for a number of factors may have an influence here. Unfortunately, it sometimes happens that we do not know when the woman became pregnant and, therefore, we cannot make a good estimation of the delivery date. For that reason, it is advisable to consider a 15 days margin and avoid being too exact, for if our estimation proves wrong we will increase anxiety.

When the anticipated date is near, the signs of what I call "an imaginary" delivery appear: the pregnant woman has contractions and pain in her lower abdomen and wants to know if she is going to find her obstetrician or his team on a long weekend or at night. Usually, once communication has been established, the so-called predelivery pain disappears and the woman feels relieved. It often happens that when she reaches the hospital she stops feeling pain and no cervix dilation is observed. So she goes back home until the next time. The pregnant woman's sensations must not be ignored because they are also a means of communication and they are true to her.

But at last delivery has started, contractions have the adequate rhythm, the uterus cervix changes, the bag of waters ruptures and the prospective mother feels flooded and increasingly afraid. This is the time when she must be reassured, given all the explanations she may need so that she can cooperate through her exercises and her rebreathing and relaxation during contractions. At the same time, those accompanying her must be spared a source of anxiety avoiding predictions regarding the exact time of the delivery, while providing adequate explanations.

When the delivery method has been decided upon, the parturient must be the first to learn about it and then those around her. The physician will never regret having given explanations before the delivery, but the opposite is often true. In this way, everybody will cooperate with him and support his work. When the second stage of labor begins, a decision has to be made as to whether or not to perform an episiotomy. Once in the delivery room, with the baby's head engaged in the perineum, we have often wondered if it is really necessary or simply easier for the doctor.

We do it in the belief that we are thus preventing a future prolapse, but is it really always so? It depends on the fetus-perineum relation and on the latter's resiliency, and it should never be carried out as a routine procedure. There is no such thing as routine in medicine; we are always dealing with individual cases and many factors must be taken into account.

What really shows the obstetrician's ability beyond his technical ability is his patience and his wish to support the woman in labor at this sublime moment of her life.

It has been said that we choose this speciality because we are "frustrated mothers", and with good reason, too. A smile, bonhomie, patience and respect will make good obstetricians of us.

During delivery, several people cooperate with the physician – the midwife, the doula, the neonatologist, the anesthesiologist and the nurse – but they can also interfere with it. What is important in a professional team is that one should take command and the others cooperate withouth replacing him. Each has his own field of activity and their roles during delivery are quite distinct.

Delivery is such an important moment that it should be experienced in a placid, homelike atmosphere. The prospective mother should not feel the protagonist of a drama but of a happy physiological event.

After the delivery, daily visits strenghten the affectionate bond between the doctor and the puerpera and her gratitude for a successful delivery. She feels she is in the center of the stage and the protagonist of everything that is happening. She receives presents and congratulations from all her relatives and friends, and from those acquaintances who only turn up on special occasions, births, wakes or weddings. This can be truly overwhelming, but she always welcomes her obstetrician, with whom she has shared the happiest experience of her life: becoming a mother.

When the newborn is brought to her, the mother experiences the baby as an extension of her pregnancy, a part of her now shared with her husband, her relatives and friends.

The third day after the delivery is crucial; I call it "the crossroads of puerperium". On the third day the episiotomy becomes particularly annoying, breastfeeding begins (up to now it has been only colostrum) and, above all, the brand-new mother has to go back home and leave the center of the stage. For all these reasons, the first post-delivery depression sets in, and the doctor must recognize it and try to alleviate the anxiety it brings about. The day has come for the mother and her baby to be discharged and she will have to cope with the baby's crying all by herself and learn to tell whether the baby is hungry or needs affection or more communication. On top of this, she cannot walk well, or sit well, because of the episiotomy and the breast congestion and, when she realizes she cannot run her house the way she used to before she became pregnant, the brand-new grandmother turns up. She should help the mother without trying to replace her. She can clean the house, help to put the baby to the breast, but she cannot feed the baby instead of the real mother. The grandmother often "advises" the young mother to go to her house until she feels better, but this would be a serious mistake. The poor husband, who has already been replaced in his wife's affection by the baby, drifts from his own house to his mother-in-law's, carrying diapers and other necessary things, and never feels comfortable anywhere. The couple must face their return home from the clinic and the grandmother should realize she is supposed to help and not to replace anyone.

There is now a slight apparent separation between the obstetrician and the couple and, if everything goes well, they meet again 30 days after the delivery, at the physician's office.

Why that day and at that place? Thirty days after the delivery important things have happened. The episiotomy has already healed, the mother can walk better, she can be examined and discharged, and given advice as to responsible parenthood.

But in those days there ensues a second emotional depression, brought about by the fact that the baby has colics, the mother's milk has diminished slightly and she is supposed to return to her husband, specially from the sexual point of view, and she thinks she will not be able to divide her love between the baby and her husband. That is why she gets depressed. Sometimes the neonatologist who has been in charge as from the delivery and has replaced the obstetrician those first thirty days erroneously insists that the baby should be given a complement, instead of waiting until this five-to-eight-day period is over. But that day also marks the mother's separation from the obstetrician, and represents a true mourning, both for the woman and for the doctor, who will not see each other for at least six months after having shared so many happy moments.

What happens when those moments are not so happy? What about the exceptional cases when the baby dies or has a malformation? This is when the obstetrician's true character is shown in the way in which he copes with the situation he shares with the woman who set all her hopes in him and trusted him with her safety as well. Most often, the mishap is not the doctor's responsibility, but he will have to give all the explanations the couple may demand from him and all the moral and emotional support they may need. A physician will never regret having adopted an active, explanatory attitude but he will regret it if he tries to escape from reality.

From another point of view, what must be the obstetrician's academic, teaching and social attitude?

When I started working as a specialist, being a general practitioner, and particularly an obstetrician, implied being respected. His academic background had real value, the fact that he had been trained by a distinguished professor gave him prestige and it was said of him that he belonged to this or that school of obstetrics. At present, all this has been lost. On the whole, medicine has been lost. The struggle for life, the economic difficulties have led to the physician becoming a worker and a bureaucrat. He has lost his individuality and become one more name on the list of a health system. But a name is not a human being, with the affection and the personality the obstetrician used to have. Unfortunately, with this loss of image, the respected, prestigious figure of the past has also been lost. The current low academic level leads to his not being interested in teaching. He thus misses the experience of feeling the teacher of young people. At present, young doctors rely only on the high-tech apparatuses instead of listening to the words and examples of their teachers. Therefore, the teacher has disappeared from the daily world of current medicine. A pregnant woman goes to the hospital or to the clinic and does not ask for a specific doctor because she does not

know any who can provide her with the communication, the affection, the understanding and the support she needs in that period of her life.

This makes us think that the social role a physician must play as regards the community has also been lost, and that current social problems, like pregnancy in adolescence, unmarried mothers, the need to promote breast-feeding, to mention only a few examples, are now in the hands of sociologists, psychologists and pediatricians, because we do not work together to achieve a common goal: to support the woman who is going to become a mother.

For the same reasons, medical societies in this field have seen their level diminished and no interesting scientific papers are read. They only deal with clinical cases, the use of medicines promoted and financed by the laboratories, but very seldom do we hear anything about the social problems and the teaching activity they require.

The same happens with medical congresses, where the same issues are dealt with over and over again until they are no longer fashionable and until the technology that manufacturers are always trying to promote has become obsolete.

When, as an exception, social issues and not clinical cases are dealt with at a medical congress, it is the community at large and not the medical community that supports and welcomes them.

The future looks grim, and the way to prevent this would be for the obstetrician, the clinicians and academics at large to breach the gap between them and the community so that their experiency may help to prevent the pre-natal complications that their current aloofness brings about.

If we achieve this goal, we shall have improved our relationship and, rather than curing, we shall have learnt not only how to cure but also how to listen to and participate in the world around us.