Teaching Clinical Obstetrics

A Short Note

Control over reproduction, fertility and sexuality has been increasingly slipping out of the hands of women. It is the policy-maker and even more importantly the medical professionals who have usurped control over reproductive decisions. In such a context it is not surprising that one of the most widely used textbook of clinical obstetrics treats pregnancy and childbirth as entirely a medical concern.

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In the practice of obstetrics and gynaecology we come across problems, which call for a holistic approach to reproductive health care where we need to go beyond the medical and surgical treatment and understand the influence and implications of social traditions and attitudes of family and community. We need to develop policies and programmes, to focus attention on health risks associated with gender-based discrimination, abuse and violence besides health risks associated with pregnancy and childbirth.

Textbooks of obstetrics and gynaecology, mostly emphasise biological or sex differences as an explanation for various diseases. Gender analysis, while not excluding biological factors, considers the critical role the social and cultural factors that promote health and sickness. The purpose of gender analysis is to identify, analyse and correct the inequalities that arise from these differences. Women's sense of well-being, the silent morbidity load they carry and their lack of access to health care systems, are increasingly being recognised by gender-sensitive research studies.

The various health policies and programmes starting with the National Family Planning in 1952 to the current Reproductive Health Programme, 1997 – have not benefited women at large the way they were intended to. Minimising gender bias depends in part on systematic approaches to building awareness among service-providers and other steps to improve access and affordability. Studies from rural communities in west Africa, show that women are not always treated with respect by health providers. In many societies, women complain about the lack of privacy, confidentiality and information about options and services available. Women sometimes prefer traditional healers because they take time to explain the illness and communicate in an understandable and sympathetic way.

Usually women's ill health is looked upon as infections, obstetric and gynaecological disorders, medical disorders, mental disorders, malignancy, etc. Instead one should look at the cultural, social and psychological setting in which these problems arise. Social injustice, discrimination, malnutrition, insecurity, neglect as well as sexual and physical abuse, lead to emotional and physical trauma in various phases of life throughout childhood, adolescence and reproductive year periods, as well as during old age. The Inter-Agency Group for Safe-Motherhood, composed of six leading international agencies, has identified the major medical causes of unsafe motherhood, their origins in medical and health system failures and in the failures of social justice that underlie them. These include women's inadequate education, low social status and lack of income and employment opportunities. It is important to impart this knowledge to undergraduate medical students. Reviewed here is Mudaliar and Menon's *Clinical Obstetrics,* 9th Edition, Orient Longman, a textbook popular among students all over the country.

The first edition was published in Great Britain and the first Indian edition was in 1962. The ninth edition was published in 1990, and has been reprinted every year till 2002. This book places an emphasis on clinical and practical aspects of obstetrics. It also gives a description of management of obstetric emergencies at the primary health centre.. Being an Indian textbook most of the descriptions fit the Indian scenario. It has considered the rural and underserved population as well.

Pregnancy and delivery are physiological process – but they can be pathological when complications and problems set in. The term gender is not used anywhere in this text. As the term clinical obstetrics implies, the descriptions are basically 'clinical' and most of the time the book fails to go beyond the 'clinical set-up'. As a result a woman coming with normal pregnancy becomes a 'patient' in the textbook. Most often the term 'patient' is used to describe women in normal pregnancy and labour. For example, for checking blood pressure (p 73). "The estimation of the blood pressure should be made after the patient has been at rest for a while". And for the conduct of normal labour (p 103) "preparation of the patient", "patient in labour". And so on. This is an insensitive way of addressing women. In other situations, the word 'cases' is used instead of 'patient', e g, I feel terms such as these make medical students insensitive to the reality that these are normal women.

The women's first childbirth represents her passage from one phase of life (daughter, unmarried, childless) to another. This change in her life has psychological and social and biological aspects. She will rely primarily on her personal network – family friends and religious support and traditional practitioners – during this passage. This personal network will have more logical and cultural variation than is found in medical care. It is important to recognise that a women's personal network and background make up the framework within which the medical care must function.

The Mudaliar textbook offers the following as the objective of antenatal care, "that the woman maintains good health throughout her pregnancy and is delivered safely of a healthy live child", (p 72). Although this is the essence of antenatal are in the medical sense this definition could be made more gender sensitive by stating that the objective of antenatal care is to ensure that the

woman reaches the end of pregnancy, physically and emotionally prepared for delivery, to promote the awareness of the social aspect of child bearing, to ensure the husband's and family's participation to help and support promotion of breast feeding, to ensure the husband's support for planning future contraception.

An important topic missing in antenatal care is preparing for parenthood. There should have been some discussion to enable the medical students to understand the importance of preparing the couple for matters related to childbirth. This would have helped them understand the feelings and thoughts of the pregnant women about her growing child and the apprehension she will have regarding childbirth. This will also make them sensitive towards the women and to motivate them to offer a sense of trust and security to the women in labour and help them to understand her anxieties and apprehension in the labour room rather than treating her as a 'patient'. In the categories of patients designated as high risk (p 81), gender-based violence as a high risk factor is missing. Violence during pregnancy is an important cause for delay in seeking antenatal care, and for poor weight gain, low birth weight and bleeding during pregnancy. This aspect is not highlighted anywhere in the textbook.

While discussing the causes for hyper emesis gravid rum, it is stated that "many believe that almost all cases of hyper emesis have a neurotic basis" – which is a rather insensitive statement that has not been properly substantiated. There are other insensitive statements too. For example, in the chapter on intrauterine death of the foetus (p 221) the treatment part ignores the woman as a whole. The authors suggest "After intrauterine death has occurred, no harm is done if the patient is left alone for two or three weeks". In the strict medical sense, this is true, but the statement ignores the emotional and psychological effect of intrauterine death. The mother will be frightened by the knowledge of bearing a dead baby, and will be shocked by this. To have a sympathetic and supportive approach is very important. Unless this aspect is included the doctors may become insensitive and unavailable for emotional support.

With development and advances in technology, the care of the pregnant woman and the foetus has become highly medicalised. We tend to view the pregnancy as having to do with the uterus and the contents of the uterus alone. The textbook description mostly conforms to this pattern. For example on p 96, the mechanism of labour is described like this: "The three factors concerned in labour are: the pelvis and soft parts, the foetus and the uterine forces. Variation from the normal in any of the factors may affect the mechanism of labour." But the main actor, the woman in labour is ignored as a human being as is heremotional state. Also women are called upon to rely on their physical stamina during labour. This also effects their whole personality and emotions. Inclusion of these aspects in the chapter would make it more gender-sensitive.

Under antenatal care, the medical description of the frequency of visits and other details are given – but how to organise the antenatal clinic in a woman-friendly way and to provide privacy and the ways of maintaining the dignity of the women is not described. Under obstetric examination, the authors state, "a careful gentle vaginal examination should be carried out". But no mention is made about getting the consent of the woman, informing her what to expect, getting her confidence, ensuring privacy before carrying out the examination.

On the use of episiotomy (making an incision to open the vaginal aperture during labour), the book states "routine episiotomy is not recommended". This is a welcome suggestion. They have described how to save the perineum and the need for an indicated episiotomy. But getting the women's consent prior to episiotomy and discussing this issue with her during the antenatal period or early in labour is not included. Indications for episiotomy have not been detailed. Being a surgical procedure, details of how to give infiltration anaesthesia and how to conduct a proper episiotomy are not provided. The immediate and delayed problems to the woman due to episiotomy are not given. Usually the woman experiences pain or discomfort, which can affect her ability to care for the new born. Later there may be pain during intercourse, which can lead to physical, psychological or social problems. It has been linked with marital breakdown. If these details are included, it could sensitise the medical student in a better way and equip them to deal with such issues in a gender sensitive way.

On perinatal mortality, the psychological effects of perinatal death are not discussed. The loss of a baby in the perinatal period is traumatic event that has far-reaching consequences for the bereaved parents. The need to be sympathetic and supportive to the parents and how to convey the message in a sympathetic way is not included.

The chapter on maternal mortality has gone beyond the clinical set-up and gives both social and clinical perspectives of maternal death. The authors say, "Socio-economic standards influence maternal mortality significantly. In the developing regions efficient antenatal care is available to only a fraction of those who need it. It is needless to state that well trained doctors, nurses and midwives form the backbone of any efficient obstetric service and all these factors along with education of the public to utilise such services influence the maternal mortality rate". Also while discussing maternal death due to abortions, the book mentions, "all that can be stated is that while deaths from puerperal infections have been significantly reduced, those from abortions with infection have not been reduced correspondingly. A larger number of deaths from infections are now from abortions." But what are the social and gender factors contributing to this? These details, if included would help the medical students to understand the underlying picture under other causes of maternal mortality, some statements are insensitive. For example, "many deaths from this category are from avoidable factors. Obstructed labour and mutiparity are the common causes. In the developing countries, with paucity of antenatal care, and ignorance or unwillingness on the part of the pregnant mothers to attend hospital early, rupture of the uterus still constitute a major problem" (p 476). This statement tries to put the blame on the pregnant mother, thus concealing the real picture of the plight of the women of low socio-economic status. One should highlight the real reasons for the delay in seeking care so that the students are sensitised to the women's situations.

There are however many positive suggestions in the book. For example, "From this brief survey, it will be observed that while maternal mortality is considerably reduced, it could be reduced still further as many of the deaths are preventable and this can be done only by major improvements in socio-economic standards, education of the population and establishment of a proper obstetric service available to all". This is a vast problem but it has to be solved. In India, the applications of the existing knowledge and the best care to all groups of the population would itself produce a pronounced fall in the rates of deaths and disease and a positive gain in the health of the women. Obstetricians have

become increasingly aware of the way in which their patients, the maternity services and their efficiency are affected by the broader society and how the health and happiness of families are in turn affected by their own techniques and approach. Many aspects of personal and community have an effect on the child-bearing potential. Women from rural and urban areas from different regions in the same country face childbirth with different obstetric risks. Reproductive efficiency is, therefore, influenced by the factors outside the control of the obstetrician and the selection of the most appropriate group of the population for specialist and hospital care is of the utmost importance. Faced with a great dearth of specialists, doctors, nurses, midwives and health visitors it becomes necessary to make a rational selection and identify the high-risk groups so that appropriate method of treatment could be applied to such groups. In the developing countries with limited obstetric and financial resources, such a policy of rational selection is the best way to make use of the limited means and reduce maternal mortality further. With the limited resources at present available, it would be essential if existing facilities are to be utilised to the fullest benefit of the community, to restrict institutional deliveries under specialist care to the 'risk' cases. Domiciliary midwifery has to play an important role and it should be strengthened by the addition of more and better trained personnel – doctors, nurses, midwives, health visitors, social service and other ancillary personnel. In addition, there should be integration of the domiciliary and institutional services. Only then will the existing facilities yield better results and maternal mortality further reduced

Role of Men

The role of men and fathers is very important in pregnancy, childcare and related matters. Men's responsibility and role in conception, pregnancy, breast-feeding and contraception are important for increasing women's accessibility and utilisation of health care services. This aspect of pregnancy and childbirth is not discussed in a meaningful way in the Mudaliar textbook. For example, in the antenatal care, encouraging men to accompany their wives to the clinic and how to set up the clinic so as to encourage the presence of men is not included. Also how to increase men's supportive role is not discussed.

On the treatment part of sexually transmitted diseases (STDs), like gonorrhoea and other STDs, the need for partner identification and treatment is not included. In the management of tropoblastic diseases (p 198), it is important that men should be involved particularly as this is an abnormal pregnancy which needs follow up for 1-2 years after. It is important to avoid future pregnancy, as it will interfere with the follow up. Barrier contraceptives are the only acceptable means of avoiding pregnancy in this case. Considering the lack of autonomy of the Indian women in negotiating condom use by their husbands, it is important to highlight the need to involve the husbands in the treatment and follow up. Unless such aspects are taught to students they will not be able to give appropriate care and counselling to such couples.

None of the national programmes find space in the book. Being a book dealing with reproductive health, it is important because the health care delivery in India is basically through primary care. This is carried out through the various national programmes.

Conclusions

Reproduction has become a medical specialty and its control has been removed from the community and women and is now being vested with the medical and midwifery professionals. Because of this transformation, women may be forgotten and their input in formal decision-making ignored. Textbooks in this speciality also propagate this trend. In fact, the whole process of childbirth is medicalised in the book. The role of gender-based violence in the causation of various health problems in pregnancy is missing. Studies show that nearly 40 per cent of women suffer from domestic violence. Apart from the physical injuries that result directly from the violence, there are a number of health problems attributed to the violence. Violence has been linked to the increased risk of adverse pregnancy outcomes like increased risk of abortions, pre-term labour, intrauterine growth retardation, etc. Under the aetiology of these conditions the role of gender-based violence is not included. The social and psychological aspect of childbirth is missing except in a few situations, e g, maternal mortality. Other issues like winning the confidence of the woman, getting her consent for various examinations and procedures, ensuring privacy, need for proper communication, empathy, encouraging men's participation, are not highlighted. EPW

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