Hughes, D. C. (1956). *Lancet*, **2**, 685.
Janssen, G., Staemmler, H. G., and Heuter, W. (1959). *Arch. Kinderheilk*, **159**, 156.
Kuntze, C. D., and Sison, P. (1957). *Amer. J. Obstet. Gynec.*, **74**, 498.
Lemere, P., and Lasater, J. H. (1957). *Northw. Med. (Seattle)*, **56**, 1176.
Lindley, J. E., Rogers, S. F., and Mayer, J. H. (1957). *Obstet. Gynec.*, **10**, 582.
MacVicar, J., and Murray, M. H. (1960). *Brit. med. J.*, **1**, 595.
Matthews, A. E. B. (1963). *Brit. med. J.*, **2**, 423.
Mitchell, E. H. (1956). *J. Amer. med. Ass.*, **161**, 44.
O'Donoghue, R. F. (1960). *Brit. med. J.*, **2**, 1022.
Pollock, G. B., Spitzer, J. J., and Mason, D. J. (1960). *Obstet. Gynec.*, **15**, 504.
Sprague, L. D. (1957). *Obstet. Gynec.*, **9**, 633.
Wegryn, S. P. and Marks, R. A. (1958). *J. Amer. med. Ass.*, **167**, 1918.

PERSONAL POINTS OF VIEW

SOME THOUGHTS ON DEATH

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Death is feared because it is The Unknown.

We do not fear the unknown in earliest infancy, but only as we come to doubt our ability to cope with it.

In the medical schools death used never to be discussed. The emphasis was rightly on diagnosis of disease, prognosis, and treatment. The word death only appeared at the end of the list of complications and sequelae, and the fact of death was recognized only as the Portal of Entry to that Other Department where the problems of morbid pathology were investigated. This was all very right—but an utterly wrong approach to death for the general practitioner.

In general practice one finds that death is commonplace, occurring like birth (being born, not giving birth) regularly once in each lifetime. We spend much time and care in preparation for birth. We should spend as much in preparation for death. Birth is the final and irrevocable end of the foetus, when it is deprived of its essential vital organ of respiration and assimilation.

Before birth very little of our antenatal care is directly concerned with

the foetus, and most of it is directed to the other people concerned, certainly the expectant mother, the midwife, the obstetrician, the home help, the anxious father, the interfering grandmother. Then, with the division of the umbilical cord, much care is directed to the newborn—we have no foetus. Birth has been a metamorphosis, the foetus has discarded its vital organ and become the newborn. This we try to arrange to happen at term. We try to avoid both premature and postmature birth.

We should approach death in much the same way. Most certainly do all we can to prevent premature death, and surely not try to enforce postmature death.

When impending death has been foreseen, whether days or months before, we can attend the needs of our patient more closely than the needs of a foetus. The patient, being probably geriatric, needs care and attention in an infinite variety of ways, all directed towards promoting his comfort of body and peace of mind, and supporting the inefficiencies of his failing organs. There is not " nothing more that we can do "—there is a great deal if only to stand and wait and pop in and say " How do you do "—keeping a sharp eye open.

We must not forget the relatives in our ante-mortal care. They must be prepared to accept a normal physiological metamorphosis at term, and to bear the stresses and strains which may precede it.

Death, particularly of a near and loved one, may have sequelae in the relict. Fear, guilt, as well as, or even exceeding, loneliness. These can be avoided by adequate care in advance. The knowledge that they themselves were fully involved in all the care and forethought will remove guilt, and if it has been possible to introduce the idea of normal metamorphosis, fear and loneliness can be much diminished. Metamorphosis, of course, is a word which should not be used, and strictly this part of the work should fall to the priest—but where do we draw the lines between care of the body, care of the mind, and care of the person?

When the foetus discarded its vital organ it did not cease to exist, though it was never again to be intra-uterine. When the elderly discards his body he will never again be mundane, but—we will have done our part.

SOCIAL ASPECTS IN THE TEACHING OF OBSTETRICS AND GYNAECOLOGY

A recent report by the World Health Organization[1] underlines the need to give to undergraduate and postgraduate students instruction in the social factors, including cultural habits and religious beliefs, that may have an influence on the medical problems of their patients. This is particularly important and obvious in relation to obstetrics, and through obstetrics to gynaecological problems for the two are inextricably related. The World Health Organization selects perinatal mortality, birth weight and

1. *Wld Hlth Org. techn. Rep. Ser.*, 1963, No. 266.