THIRD SESSION

THE FOETUS AT RISK

Chairman: Sir Hector MacLennan (*President of the Royal College of Obstetricians and Gynaecologists*)

Dr Arthur Nelson, M.B., Ch.B. (*general practitioner, Glasgow*)

In introducing the sessional chairman, I would draw attention to the *British Medical Journal* of 30 April 1966, which states that the task of supervising the production of a well baby by a well mother should continue to be part of general practice. It says there are about a million mothers to be delivered each year, and the State will certainly go on making it financially rewarding to practise general-practitioner obstetrics. " We recommend with the full support of the College of General Practitioners that future general-practitioner obstetricians should serve six months in an obstetric hospital." Even if we all did this, there would still be need for constant refresher courses, and in this respect Glasgow is uniquely placed. In addition to the maternity sections in our various hospitals and the Royal Maternity Hospital in Rottenrow, we have the large Royal Hospital for Sick Children and the new and also large Queen Mother's Hospital, forming a complex which is physically as well as administratively a single unit—or should be, for at the moment, owing to structural defects, the sick children's part is out of action. It is a most distinguished team from these two hospitals which will talk about the risks to the foetus and newborn. In the evening we will visit the Queen Mother's Hospital. This is a completely new teaching hospital, and one of its features is that accommodation there is reserved for any general practitioner who cares to spend a week, say, in studying obstetrics, and in fact learning midwifery by taking part in it.

Sir Hector MacLennan, M.D., M.B., Ch.B. (*President of the Royal College of Obstetricians and Gynaecologists*)

In taking the chair, Sir Hector MacLennan remarked that the Royal College of Obstetricians and Gynaecologists have

always held that midwifery should be teamwork and the product of teamwork, and that the team should comprise the obstetrician, the practitioner and the midwife.

ANTENATAL FOETAL HAZARDS

Professor Ian Donald, *M.B.E.* (*Regius Professor of Obstetrics and Gynaecology, University of Glasgow*)

The object of the exercise is surely to produce a live baby and a healthy baby. We have hitherto made the mistake of regarding antenatal care which is adequate for the mother as being automatically adequate for her baby. This is not necessarily true. We smile indulgently at the people who compare the antenatal care of today and yesterday in terms of maternal mortality. Today, perinatal mortality is accepted as an index of effective treatment. But I would like to go further and ask, " What about the survivors? " It may be dangerous to extrapolate from perinatal mortality to physical wellbeing in those that live. After all, our interest is with the living and not with the dead. It is not enough for the baby to be put down in the notes as " alive and well ", but we should be told how well.

Everything that happens *in utero* may have far-reaching effects on that baby's intellectual and physical capacity or on its subsequent handicap. We believe that there must be a reason for everything, or there would be no point in calling medicine a science. Even asphyxia, to which such a high proportion of dead babies is attributed, must have a cause, and yet so often nobody bothers to seek any further. Foetal abnormality, too, can hardly be accepted as an act of God, and as for prematurity, this is still one of our biggest factors in loss, so let us examine the size and relative distribution of the problem. The figures we have analyzed from our practice in Rottenrow are large enough for us to talk sense about them. Tables I and II show how relatively rare is fresh stillbirth—the macerated stillbirth is a far bigger problem. The big sections are foetal abnormalities—particularly anencephaly and hydrocephalus—abruptio placentae, or as it used to be called, concealed accidental haemorrhage, pregnancy toxaemia, and unexplained intra-uterine