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.

gynaecological cancer as three examples of conditions in which social aspects are important and it also points out that an increasingly large proportion of maternal deaths follow abortion, usually illegal, a problem that has been met in some countries by providing birth control, and by legalizing abortion in others.

Just as maternal mortality is related to unwanted pregnancy, so it may be that many cases of prematurity and perinatal death also follow unwanted pregnancy in women who lack the ability or determination to arrange an abortion and react to the situation by making inadequate provision to secure continuation to a successful conclusion. Carcinoma of the cervix is also a social problem in that it is more frequent in the lower social classes and is now thought to be related to frequency of intercourse and type of contraception, as well as to parity.

Rapid progress in dealing with the medical problems of obstetrics and gynaecology has been made in the last 30 years. Awareness of the importance of social factors has developed more slowly and the World Health Organization gives a timely warning that "a great responsibility rests with the heads of departments of obstetrics and gynaecology and with their staffs to achieve a broadening of the curriculum and a resulting change in the medical student's approach to his future patients, their families and communities". Where they exist, heads of departments of general practice have a great responsibility in this matter, including that of influencing the more specialized departments to take appropriate action.

The Royal Photographic Society of Great Britain

Medical Group

The Combined Royal Colleges Bronze Medal donated by the Royal Colleges of Surgeons of England, the Royal College of Physicians of London and the Royal College of Obstetricians and Gynaecologists will again be awarded in 1964 to any person of any nationality, whether a member of the Royal Photographic Society or *not*, for an outstanding example of Photography in the service of Medicine and Surgery.

Work submitted or nominations for the award with a written statement outlining the grounds on which the submission is to be judged, as well as details of the type of material to be submitted, i.e., prints/transparencies, film size, 16mm,. 8mm., 35mm., sound/silent, should be received by the **honorary secretary of the Medical Group of the Royal Photographic Society, 16 Princes Gate, London, S.W.7 by 30 September 1964.**

Work of sufficient merit may be nominated by anyone for consideration for this award.