EDITORIAL

Obstetrical Anaesthesia

It is unfortunately true that Anaesthesia for the obstetrical patient has received too little attention from anaesthetists. There have been several reasons for this neglect. Many anaesthetists, being otherwise adequately employed, have shunned obstetrical anaesthesia because of its demands on their time, particularly at night, and because of the numerous rush calls of an emergency nature which it entails. Others have considered it minor anaesthesia, taking little real interest in the unique problems involved. Many members of the profession have undoubtedly believed that the obstetrical patient requires so little anaesthesia in most cases that the services of an anaesthetist are not warranted, and this attitude has been prevalent enough to make it possible in the recent past for a medically sponsored plan for prepaid medical care to make no provision for obstetrical anaesthesia.

The serious need for expert attention to the problems of obstetrical anaesthesia must be apparent to all when it is considered that aspiration of vomitus during delivery remains an important cause of maternal morbidity and mortality, that the part played by anaesthesia in neo-natal death is yet far from being defined, and that many infants still succumb to asphyxial incidents at birth who might be salvaged by the expert care which a qualified anaesthetist can provide.

Fortunately a number of well qualified anaesthetists have in recent years turned their attention to the problems involved in providing analgesia and anaesthesia for the obstetrical patient during labour and delivery. Their studies and experience have resulted in greater understanding of the problems involved, and in the introduction of many new techniques for dealing with these problems. There has also developed an ever-increasing awareness of the benefits to be derived by the patient from intelligent cooperation between the obstetrician and anaesthetist throughout the labour More thought has been given alike to the factors which produce pain in labour, and to the effect of conventional methods of pain relief on the course of labour.

It becomes increasingly apparent that routine treatment of all obstetrical patients by one method of pain relief is unsatisfactory, if not, in fact, dangerous practice. Yet publications on the subject continue to appear suggesting that all obstetrical anaesthesia should be managed by one technique, to the exclusion of all others We believe that however satisfactory the results may appear, such an attitude will lead to application of the method blindly, and to the detriment of some mothers and infants.

We have the good fortune to present elsewhere in this issue a series of three papers on various aspects of obstetrical anaesthesia. These illustrate the valuable part being played by the Vancouver group of anaesthetists in the development and evaluation of methods for the relief of pain in labour, and the provision of safe anaesthesia for obstetrical delivery.