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SPEECH BY PRESIDENT SHEARES AT THE KANDANG KERBAU HOSPITAL
RECREATION CLUB DINNER AND BALL ON SATURDAY, 23RD NOVEMBER
1974 AT THE HYATT HOTEL AT 8 P.M.

I am happy to have been invited by the chairman and organising committee of the Kandang Kerbau Hospital Recreation Club to their second biennial dinner and ball. I have been informed that membership of the Recreation Club comprises all grades of staff working in the hospital, and that members are such good sportsmen that they make every endeavour to turn up when selected to play a game. If the team-work of the club, as a whole is in the future kept at the same high pitch as it has been since its inauguration in 1964, then you will advance from good to better. I am sure that the prizes that will be distributed tonight will meet the approval of most of your club members - I know that they will be met with acceptance by the winners!

My first acquaintance with the Kandang Kerbau Hospital dates back to early 1927 when I was posted there for 12 weeks clinical duties as a medical student of the King Edward VII College of Medicine.

The Free Maternity Hospital in Victoria Street had moved to the present site of the Kandang Kerbau Hospital in October 1924 and occupied the two original one-storey buildings erected on the site in 1860 as a General Hospital. This year, therefore, is the 50th anniversary of the Kandang Kerbau Maternity Hospital.

In 1927 the hospital provided only 34 beds which were insufficient for the number of admissions and gross overcrowding was evident. Expansion of the hospital was inevitable and this took place in stages.

One of the old buildings, that nearer the canal, was pulled down and a 3-storey block of 120 beds was erected in 1934. The total number of births in the hospital that year was 2,575. However, the number of deliveries continued increasing so rapidly that another new

Block was erected on the site of the old rear building, increasing the number of beds to 180 when it was opened in July 1940. The total number of births for that year was 6,184 - all free cases. The paying patients and all gynaecologic cases were treated at the General Hospital, Outram Road.

In December 1941, on account of hostilities with the Japanese, it was converted to an emergency General Hospital to deal with the large number of casualties due to bombing and shelling. During the Japanese occupation it served as the Civil General Hospital until 1946 when it became, what it continues to be, a specialised hospital for obstetric and gynaecologic cases.

In October 1953 the foundation stone for new expansions including the new hospital wing, the outpatients department, the laboratory and the students' hostel were laid and these buildings were completed on 10th August 1955. The total number of hospital beds was increased to 316.

Over the years since 1955 expansions have taken place and it now has 560 beds excluding beds in the labour wards used for delivery purposes. The record number of deliveries in the hospital was 39,856 and that occurred in 1966, but there was a drop to 30,022 in 1971 due mainly to the successful family planning campaign conducted by government.

When I qualified in March 1929, I was posted to the Medical Unit at the General Hospital, Outram Road, for 2 years and in April 1931 was transferred to the Obstetric and Gynaecologic Unit of that same hospital as assistant to Professor J.S. English.

However, in 1938 the doctor in charge of the Kandang Kerbau Hospital resigned and took to private practice. Professor English wanted to transfer me to the Kandang Kerbau Hospital but I told him I was interested in Gynaecology. He was accommodating and arranged for the new assistant he had taken on to take turns with me on duty at the Kandang Kerbau Hospital every alternate month. This system carried on until the hospital was converted to an Emergency General Hospital to deal with casualties during the Japanese hostilities. Then both his assistants were posted to the Emergency Hospital together with several other doctors transferred from the General Hospital, Outram Road, and others who had trickled down to Singapore from Peninsula Malaya as the Japanese Army fought its way down to Singapore.

In 1929 when I first took up training in Obstetrics and Gynaecology, the so-called blessed events of women in their biological role of mothering a new generation were ordeals which carried women to the very depths of misery unless benign physiological resources came to their rescue. Professor English used to stress that labour should be left to nature and there should be no "meddling". It was not unusual for some patients to be in labour 3 to 5 days. Many of these women were subsequently injured by exceptionally traumatic procedures, by the vaginal route such as high forceps, embryotomy and extraction and often they died of haemorrhage. Caesarean section by the classical method was resorted to only in cases of very obvious gross contracted pelvis. I recollect that only 3 or 4 such operations were carried out per year in the 1930's.

The favourable change in mortality due to haemorrhage has resulted from the greater security we now have in performing the lower segment caesarean section under the trying condition which forced us in those early days to gamble for the lesser mortality of vaginal delivery even when perforce it had to be traumatic in nature. It is quite clear therefore that the improvement in death rate due to haemorrhage is hidden in the magic of antimicrobial agents that so dramatically influenced the caesarean section outcome.

It is unfortunate that the records of the obstetric mortality rate and the neonatal mortality rate in the 1930's have been lost or destroyed. I recollect that the figures were approximately 8 to 9 obstetric deaths per 1,000 deliveries and 60 to 70 neonatal deaths per 1,000 deliveries.

The records of the Kangiang Kerbau Hospital relating to Obstetric and Neonatal Mortality date back only to 1955 and they indicate that in that year the obstetric mortality at the hospital was 9.5 per 10,000 deliveries. In 1960 it was 6.6 per 10,000 deliveries, in 1970, 5.1 per 10,000 and in 1973, 1.7 per 10,000 deliveries. The neonatal mortality was 17.8 per 1,000 deliveries in 1965 and 14.7 per 1,000 deliveries in 1973.

The fall in maternal mortality during the past 30 years has been phenomenal and quite unmatched in the history of obstetrics. There have been many factors to account for this, most of which are so well-known to you that they hardly bear repetition. One should start with the vast improvement in the competence of the obstetrician. These well-trained men were then blessed with the antimicrobial agents and the availability of blood transfusions and other agents for the treatment of shock and haemorrhage, caesarean section operation had become the most resplendent tool in the obstetric armamentarium. The increased use of hospital facilities for delivery, so that a very high percentage of Singapore women now deliver their babies under its protective roof, has put home delivery in the same category as kitchen surgery. Pitocin given intravenously by experts has done much in the management of uterine inertia, premature rupture of the membranes and postpartum atony. Antepartum care with its important prophylactic impact is now an accepted part of what local women expect of their doctors. It is unnecessary to go into details of the roles played by these various factors in bringing about the dramatic change in obstetric practice and outcome.

The maternal mortality committee which functions today on a continuing basis serves as an important medium of education of the obstetrician. Quality standards and uniformity of terminology could result in the meaningful compilation of large numbers of recorded data.

The vast accomplishment of obstetric management has resulted not only in the phenomenal drop in maternal mortality but also in perinatal mortality. Our obstetric data should permit matching with the paediatric findings obtained during the early years of development of the child. In obstetrics we should follow up studies of both mothers and children. How much more we might know if we had a nearly complete ten year follow-up of babies born by breech delivery, of survivors of RH incompatibility, of depressed infants at birth or those born of diabetic mothers or any obstetric complication we can name.

Prenatal care is the sheet anchor of obstetric management. That it has done much to reduce maternal and perinatal mortality hardly requires proof.

In very recent years, prenatal care has included in its scope the diagnosis of severe genetic diseases of the foetus in utero. The personal and social costs of genetic disease reach tragic dimensions. Fortunately, the recent great strides in medical genetics are beginning to reduce some of the sorrow and social cost. Some 70 genetic abnormalities can now be diagnosed during pregnancy. In developed countries these diseases account for one third of the admissions to hospital paediatric wards and 40% of infant deaths.

Recently developed tests make it possible to detect some kinds of defective genes and people who carry such genes can be advised as to their chances of having afflicted children. Parents who want only normal and healthy children can choose abortion for severely affected foetuses.

Most mongoloids are born to normal and healthy parents. The mal-distribution that produces the dangerous triple chromosome No. 21 can happen to any woman, especially above the age of 35 years.

Though amniocentesis, which is done at about the 15th week of gestation is 99% safe in experienced hands, perhaps a procedure simpler than amniocentesis might be developed to ensure wider use of prenatal diagnosis of disabling genetic disease of the foetus. One possibility now being investigated involves the detection of foetal cells in maternal blood. This would permit prenatal diagnosis of genetic disease of the foetus by a simple blood test on the prospective mother.

Despite its recent advances, medical genetics is still a very young field, facing many unsolved problems. Researchers have so far been able to map the precise location of only about 0.01% of the estimated 100,000 genes on human chromosomes. Hence many hereditary ailments are still poorly understood. It has been possible, for example, to trace the precise cause of only one third of mental retardation cases resulting from genetic defects.

The staff of the Kangang Kerbau hospital can look backward with some pride over its history of the past 50 years. For the future there is need to go beyond the primary surgical interests of our speciality, yet maintaining these at a high level. We must achieve greater team play with the biochemist, endocrinologist, geneticist, paediatrician, psychiatrist and sociologist so that by combined efforts more will be known and more can be done in the broader scope of this important field of medicine.