Opening Remarks
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Enormous progress has been made during the past two decades in all aspects of medicine concerning birth, including obstetrics and perinatal medicine. Such fundamental changes have occurred only in very few other fields of medicine. Completely new areas have emerged whereby it is possible to gain decisive and above all diagnostic insight into the intrauterine space. I am thinking in particular of the electronic and biochemical supervision of the fetus, ultrasonography, inhibiting of labor by tocolytic agents and fetal lung-maturation diagnostic and therapy, just to mention a few. In addition we are aware that many branches of medicine overlap with the areas of obstetrical and perinatal medicine, and to a certain extent play an important part in these fields. Viewed at long-range, a great new area of medicine has emerged, including other important branches, dealing specially with the unborn and newborn infant. Attempts have been made to characterise and limit this new field. Terms such as "fetal and maternal medicine" are used in the United States, and in German-speaking countries "obstetrical and perinatal medicine", in German "Geburts- und Perinatal Medizin."

This development which is growing in our country with great activities should be expanded further on an international level. A particular aspect of our intentions in arranging an international meeting in Berlin at appropriate intervals is the fact that there is a desire in the German-speaking countries - particularly among the younger colleagues interested in perinatal medicine - to get into closer contact with excellent foreign scientists and clinicians and at the same time to get consideration in the English-speaking countries for their own valuable achievements in the field of research. A considerable amount of scientific work published in the German language is little known or even completely unknown in the literature published in English. Many experiments and evaluations have been repeated unnecessarily, although similar results had already been published. This was one of the reasons for the founding of the JOURNAL OF PERINATAL MEDICINE. Here non-English speaking authors are given the opportunity to publish their translated articles in English.

The Berlin Meeting should also help in supporting useful cooperation and in lessening paradox excesses of competency. I mean that it should be made clear that an obstetrician can act as a highly specialized expert only in very few areas of neonatology or paediatrics. Perhaps not quite to the same extent but to a certain comparative degree, this also applies to the paediatrician who would like to report more fully on obstetrical problems than the obstetrician himself. The same applies to anaesthetists and also to many other closely-related branches of medicine. Perinatal medicine in particular needs numerous contacts and close cooperation with other branches of medicine because of its manysidedness. However this must be a genuine, real cooperation based on excellent knowledge and not like a "fancy dress party" with various costumes - the title page of the Congress Programme could contribute as an interpretation of this aspect and the sometimes curious results of contribution.

Our joint congresses offer the opportunity of discussing up-to-date controversies in our field of activity. Where there has been such growth in technicalization, in methods and knowledge, it is not sur-

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prising that contradictory opinions have been expressed. Such a problem is posed in the international area of perinatal medicine by the question "How far should intensive supervision of the fetus be practised during labor?" The majority of modern obstetricians is of the opinion that all labors should be intensively supervised. A minority is of the opposite opinion, saying that this is only necessary in high-risk cases and not in so-called "normal" cases.

Arguments for the last attitude are as follows:

According to single evaluations the following opinions have been expressed: a) not intensively supervised groups do not show poor results, b) the expense of general intensive supervision would be too high, c) the patients would be handicapped, d) furthermore the intensive supervision confuses some obstetricians, and e) therefore the caesarean rate would be unnecessarily too high. I think that not too many words are necessary on this. It is too easily forgotten that priority Nr. 1 in medical care of our patients must be safety, in this case for two individuals, mother and infant. An obstetrician can spare himself such unnecessary controversies by relying on old-established, solid knowledge and logic built up on decades of experience in obstetrics.

No one, by means of correct investigational attempts, will ever succeed in proving that no complications at all can occur during the course of a so-called "normal" labor. So having acknowledged that complications can occur, which corresponds to irrevocable facts, then no one can prove that their diagnosis is just as reliable on a routine basis with traditional random sample auscultation. We have gained much experience since fetal blood analysis was introduced on a practical basis for the first seven years, because at that time continuous cardiotocography was still not in existence. The main problem then was to control often enough fetal heart-beats through random tests in order to prevent fetal blood analysis being performed too late, and thus recognizing the danger early enough. Our overall results from this period as regards intrapartum mortality and postpartum morbidity were considerably better than without fetal blood analysis, that is at the time of exclusive auscultatory heart-beats controls, but they were not so good as after the introduction of cardiotocography. Then it was possible to combine cardiotocography with biochemical and cardiotocographic intensive supervision. Those who still think today that the obstetrical stethoscope is sufficient, used by an experienced mid-wife, who must ascultate over and over again after almost every contraction, approaching the excellent results of the continuous cardiotocographic supervision, but never achieving them. It is not difficult to show as a model that good results can also be achieved by simple ascultation, but it is unrealistic because models often function only as models and not in the widely applied routine practice. Furthermore no one would suggest that a midwife be employed more or less on a non-stop basis as a substitute for a continuously working machine. It would be better to make retrospective examinations to show how poor the results in fact were on a routine basis with only auscultatory supervision in a so-called "normal" group.

When in several places no convincingly better results could be achieved with the generally used intensive supervision that with the traditional method in normal cases, this could be due possibly to

the following facts: unfortunately intensive supervision is inadequate in many instances, and not seldom almost diletantely practised. The negative criticism should not be given to the method but rather to its executor. One who supervises merely by cardiotocography must have a high caesarean section rate. He must assume hypoxia always to occur with every suspicious heart-rate pattern, which is a fairly frequent happening. Should he pay no attention to such suspicious parts in the cardiotocogramme, in order to keep down the caesarean rate for cosmetic reasons, then he must take into account high post partum morbidity and mortality. Then he may really have results that are nearly as poor as those achieved only by conservative auscultatory supervision. Cardiotocography has its great advantages and also well-known disadvantages. In almost all cases it provides early recognition of real danger but far too often suspicious heart-rate patterns occur where actually no immediate danger threatens. Therefore only combined cardiotocographic and biochemical supervision can give really accurate and optimal results. Unfortunately however this is not practised in sufficient number of instances. The other objection to intensive supervision that psychological aspects are not taken into consideration I cannot agree with. In spite of intensive supervision consideration of family aspects is still possible even in a highly technicalized labor ward. We practise this with proven success as has been confirmed by the majority of our patients in an enquiry. We and centers working under similar conditions have a post partum morbidity of seriously hypoxically endangered infants of 0.3%. Under this heading I mean an advanced acidosis of pH 7.1 or less in umbilical artery blood and an advanced clinical depression of 4 and less APGAR score. This number can hardly be further reduced. We have a correspondingly appropriate caesarean level of 8 - 10%. What we have achieved can also be realised in similar hospitals having an appropriate staff, equipment and organization.

Finally the whole complex should be seen from another viewpoint: we know that also a labor declared as normal is a relatively short period of concentrated occurrences, which mostly takes place, including the first minutes of life, within a time span of less than 18 hours. In no other period of life are we confronted with such a concentration of dangerous events within 18 hours, even when the so-called non high risk cases are involved. In order to open the eyes of many critics among some colleagues and also among laymen, I suggest the introduction of a new parameter in medical statistics - under a special aspect, namely the danger concentration per time unit dependent upon age of life. This means how many individuals die for instance during the first minutes of life or during the course of labor which is mostly shorter than 18 hours. The summit would lie in the first minutes after birth, the labor itself and the first hours of life would surround the summit and then there would be a steep drop in the curve during pregnancy, and finally the rest of our life would emerge as a very flat level line.

Knowing all this and nevertheless dispensing with intensive supervision is in my opinion uncritical carelessness. Also it is quite wrong to only add up mortality figures when considering dangers at this short period of life. The morbidity figures are rather more important. These danger concentration curves which I have described should be drawn up under various aspects.

Returning to our congress,

the international meeting is, as I just mentioned, in a position to fulfil further duties involving personal contacts between scientists of many countries. Berlin has been the home of repeated meetings over longer intervals. The 1st National Society of Perinatal Medicine was founded here 12 years ago in February 1967. The 1st International Society was founded here, namely the European Association of Perinatal Medicine in 1968. In the meantime 40 one-week introductory courses into problems of perinatal medicine have been held with strong international participation. Up to now there have been 1200 participants, 550 of whom were foreigners.

We hope that the attempt to combine this tradition with the German Congress will receive a positive echo. I offer my thanks to the speakers who have been willing to come and take part here in Berlin. I thank the participants some of whom have had a very long journey for their interest. I hope that speakers and participants will accept the style of the Berlin Congress in its present form - as a hardworking meeting, and that Berlin will provide happy memories for them.