

In June 1936, Colebrook and Kenny, in a landmark paper, reported their success in treating established puerperal sepsis in women using prontosil — the death rate in apparently similar cases dropped from around 27% to 8%. Colebrook and Kenny wrote (cautiously): “. . . the very low death rate, taken together with the spectacular remission of fever and symptoms observed in so many of the cases, does suggest that the drug has exerted a beneficial effect”.¹⁸ History was to prove them correct, and in 1939 Domagk was awarded the Nobel Prize in Medicine and Physiology for his work.

Prontosil and other sulfonamides were followed by penicillin, to which streptococci causing puerperal sepsis still remain sensitive, and the arsenal of antibiotics used for all other forms of postpartum fever today.^{3,19}

Today, in Australia, deaths from puerperal sepsis are extraordinarily rare (the MMR is currently about 0.1 per 1000 births).² However, infection and fever are not rare, and the microbes causing them are omnipresent. In caring for pregnant women, especially the many who have some intervention in labour or delivery, we would be wise to reflect that it is only the use of increasingly complex antibiotic regimens which prevents a return to “the terror of the lying-in hospitals”.

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CHRISTMAS OFFERING

The Polaris principle

As the United States' unsettling rise to hegemony illustrates, the world becomes a more dangerous place when the balance of power is altered. What is true for geopolitics is true for medicine.

I have a simple proposal for restoring the balance of power between the junior medical staff and their consultants and registrars. It relies on the well-proven theory of deterrence. It is the intern's equivalent of a submarine filled with nuclear missiles cruising off the coastal shelf of the registrar's continent.

The system works this way. At the welcome and orientation to the hospital for the new interns, the last presentation is by a well-respected intern from the previous year. Ten shiny laminated cards are handed to the shiny new interns and they are instructed in their use. They are admonished to hoard these resources, to use them sparingly and effectively.

A few weeks later the morning ward round is drawing to a close. Twenty-five patients have been seen, and seven consultations, two MRIs, a bone scan and a partridge in a pear tree have been generated for the unfortunate but uncomplaining intern. However, at last a line is crossed. A patient who had surgery the night before is rolling around in bed complaining about pain in his knee. He has a urinary catheter because he suffers from prostatism and has produced 20 mL of urine an hour from his generously sized ex-meat packer frame. One can easily see from the foot of the bed that he is as dry as a chip. The two drains appearing from under his bandages are full.

The orthopaedic registrar looks at the pulse oximeter and notes a mild tachycardia. The terrible words are uttered: “We'd better get a cardiology consult . . .” (at least his expression is hangdog).

This is the time to act. The intern pulls out his wallet and deals the “*Get your own damn consult!*” card. The registrar accepts it with consternation. He is compelled by the laws of decency and tradition to proceed. Dutifully, he calls the cardiology registrar between cases. He is greeted with the derision such an unnecessary consultation deserves. A hefty dose of humble pie is consumed.

A couple of weeks later the temptation arises for another dodgy consultation; this time, some minor basal atelectasis. Noting the oxygen saturation of 94%, the registrar turns to his intern and starts to open his mouth. The intern reaches for his wallet; the mouth is shut; the submarine descends from launch depth and the balance of power is restored.

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