PERINATAL LESSONS FROM THE PAST

Dr Edward Rigby, junior, of London (1804–1860) and his system of midwifery

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Edward Rigby was born with a twin sister in Norwich on 1 August 1804. His father was a distinguished physician-accoucheur of that city and his mother the daughter of William Palgrave of Yarmouth. He was educated at Norwich Grammar School where one of his great friends was the future Rajah of Sarawak, Sir James Brooke. Although his first choice was to go to sea, it was decided that he should become a doctor, and, after a year as a pupil at the Norwich and Norfolk Hospital, he studied medicine at Edinburgh University from 1822 to 1825. Having graduated MD on his 21st birthday, he then studied anatomy in Dublin before spending four years in Germany studying midwifery, first in Berlin and then with Professor F C Naegele in Heidelberg. Naegele had just published his important essay *On the mechanism of parturition* which Rigby translated and then published on his return to England in 1829. This book, one of the classics of obstetric literature, had a considerable influence on British midwifery. Rigby's next two years were spent as house-pupil at the Westminster Lying-in Hospital and in obtaining membership of the College of Physicians (FRCP 1843). In 1831 he was appointed lecturer in midwifery at St Thomas's Hospital and entered practice as a physician-accoucheur (fig 1). Other appointments at the Westminster Lying-in Hospital and at St Bartholomew's Hospital followed (where his colleague was Dr Charles West), and in 1841 he was appointed Examiner in Midwifery at the University of London, a post he held until his death.¹

Rigby wrote several books on midwifery including an annotated 2nd edition of William Hunter's *Anatomical description of the gravid human uterus* (1843). However, none were as important as his *System of midwifery*² published in London and Philadelphia in 1841. It was very popular, and had a profound influence on the obstetrics of his day. The extracts that follow are taken from it.

On the length of labour

"All attempts to accelerate the course of a natural labour, especially the first stage, either on the part of the patient by premature straining, or on the part of the practitioner by attempts to dilate the os uteri and passages, or by giving her stimuli, &c. cannot be too strictly forbidden . . . Quick rapid labours are

Figure 1 Edward Rigby, junior (1804–1860).

by no means desirable, for they are seldom safe . . . No conscientious practitioner, who has clear and enlarged views of the process and mechanism of natural labour, would feel himself justified in interfering with its course, merely because some portion of it has extended beyond a certain fixed period; but would rather guide his conduct by the habit and strength of the individual, and by the effects which the labour has upon her. We have before stated, that no two labours are alike; we may also add, that no two individuals are similarly affected by the same degree and duration of labour, nor indeed are any two labours exactly alike in the same person: hence it will be evident, that what to one patient would prove a protracted and exhausting labour, to another would be nothing more than a perfectly regular labour, natural both in its character and progress. Among other injurious effects which premature efforts on the part of the patient will have, is, that the membranes are liable to give way too soon – this is by all means to be avoided . . ."

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On the delivery of breech presentations

Rigby had learnt from Naegele that the frank breech was a better dilator of the cervix than a footling presentation and that it was better not to bring down the legs, as usually practised. The first stage of labour might be prolonged but the better dilatation of the cervix ensured more rapid and easy delivery of the head. He wrote:

“In no case is so much mischief done by impatient interference as in presentations of the lower end of the child. This is still more so in footling cases, for here the soft parts are not so well dilated as in nates presentations, where the child comes doubled; hence the fact, that presentations of the feet are easier for the mother but more dangerous for the child.”

On dividing the umbilical cord

“The cord should not be tied until it has ceased to beat, for unless the circulation be well established in its new course, the breathing is apt to stop, and the child relapse into insensibility: the cord should be tied about three inches distant from the umbilicus; it should be applied tightly, because otherwise it is apt to become loose, as the cord grows flaccid. . . . The cord should be divided at some little distance from the ligature, so as to prevent all chance of its slipping off, and it should be done with a pair of blunt scissors, by which means the vessels of the cord are so bruised as to be rendered nearly impervious. There is no need to apply two ligatures; in fact, it is better not, for, as Dr Dewees justly observes, ‘the evacuation from the open extremity of the cord will yield two or three ounces of blood, which favours the contraction of the uterus and expulsion of the placenta.’ It has been recommended in case of twins, to apply a second ligature, to prevent all chance of the second child bleeding through the cord first.”

On suckling to prevent postpartum haemorrhage

“The application of the child to the breast is not less valuable for preventing any return of the haemorrhage than for stopping it in the first instance: we are never perfectly secure against haemorrhage coming on during the first few hours after delivery, even where everything has turned out as favourable as possible: the exhaustion from the length or severity of the labour, the warmth of the bed, and in some cases, it would even seem, the relaxing effects of deep sleep, are all liable to be followed by inertia uteri and haemorrhage. In no way can we insure our patient so completely against this kind of danger as by putting the child to the breast; the uterine contraction which it excites is not only powerful, but permanent; nor do we consider that a practitioner is justified in leaving a patient in whom the uterus has shown a disposition to inertia without having insured her safety by this simple but effectual safe-guard.”

On the contagious nature of puerperal fever

“The contagious nature of puerperal fever has long since ceased to be a matter of doubt, and instances have repeatedly occurred by practitioners and nurses communicating the disease to several patients in succession . . . Where a practitioner has been engaged in the post-mortem examination of a case of puerperal fever, we do not hesitate to declare it highly unsafe for him to attend a case of labour for some days afterwards . . . That the discharges from a patient under puerperal fever are in the highest degree contagious, we have abundant evidence in the history of lying-in hospitals. The puerperal abscesses are also contagious, and may be communicated to healthy lying-in women by washing with the same sponge: this fact has been repeatedly proved at the Vienna Hospital; but they are equally communicable to women not pregnant; on more than one occasion the women engaged in washing the soiled bed linen of the General Lying-in Hospital have been attacked with abscesses in the fingers and hands, attended with rapidly spreading inflammation of the cellular tissue.”

At the time that this was being written, Semmelweis was still a student! Two years later in Boston, Oliver Wendell Holmes gave Rigby credit for his observations when he delivered his famous lecture on puerperal fever.

Although a slow learner, Rigby had a tenacious memory, the ability to spot essentials, and the resolution and patience to achieve his aims. He was exact and regular in his ways and very hard working and conscientious. Kindliness and service were his guiding lights and men trusted him for his honesty and straightforward dealing. With him friendship imposed a sacred obligation. Retiring and unostentatious in his manner of living, he could be firm and uncompromising in matters of principle, as when he resigned from the Westminster Hospital because the committee there had refused to accept his recommendations for controlling a serious outbreak of puerperal fever.

Rigby acquired a great reputation as a lecturer and became the leading obstetric physician in London. He believed in treating the underlying causes of disease rather than its symptoms. Many honours came his way both at home and abroad. In 1859 he helped to found the Obstetric Society of London and became its first president. He was also elected a Fellow of the Linnean Society.

In 1838 Rigby had married Susan, daughter of John Taylor, FRS, and they had one daughter before her death in 1841. Ten years later in 1851 he married Marianne Darbishire from North Wales by whom he had two daughters. In 1860 he developed cancer of the bladder and died in renal failure a few months later at his home, 35 Berkeley Square, London, on 17 December. He was 56 years old.

1 Obituary: The late Dr Rigby. *Lancet* 1861;1:20–1.

2 Rigby E. *A system of midwifery*. London: Whittaker and Co, 1841.