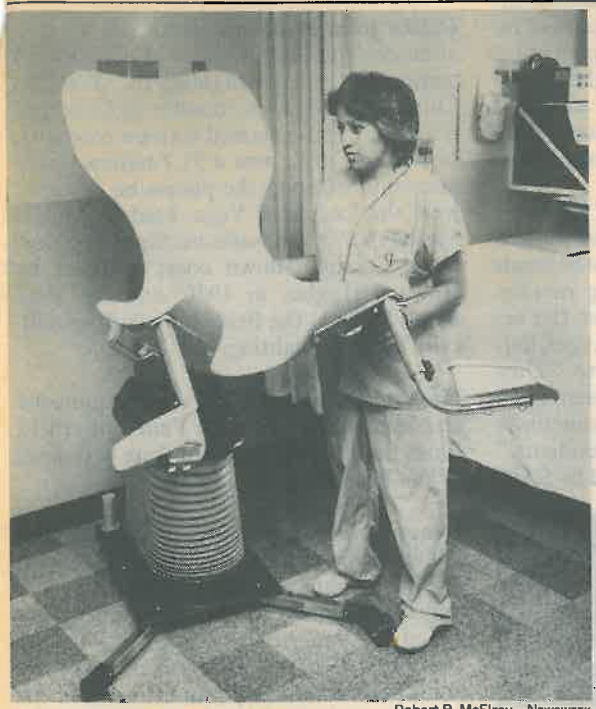

Robert R. McElroy—Newsweek

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Back to basics: Modern chair in New York, medieval European version

Childbirth Sitting Up

Nearly all mothers nowadays deliver babies while lying on their backs. This is not necessarily for the mothers' convenience; rather, it's easier for the obstetrician to listen to the infant heartbeat with a stethoscope or use forceps to help the child out of the birth canal. But after two centuries of this practice, some doctors are reviving an ancient method of delivery: the woman sits upright in a "birthing chair."

Until the eighteenth century, when physicians began to take over from midwives the supervision of childbirth, "vertical" delivery was the norm. Ancient Greeks used a chair with a crescent-shaped opening; sixteenth-century Venetian women used V-shaped stools. Sometimes, jewel-trimmed birthing chairs were part of a bride's trousseau. The chair of the 1980s, however, is totally functional. Constructed of high-impact plastic, with molded knee braces and adjustable footrests, it is motorized so it can be raised, lowered or tilted to suit the doctor's needs. The Century Manufacturing Co. of Aurora, Neb., has sold about 185 of the chairs at $5,000 each to hospitals around the country and abroad.

Delivery via birthing chair can offer several advantages. "Because of the structure of the human pelvis," says Dr. Warner Nash of New York City's Lenox Hill Hospital, "delivering a baby is best and most naturally done in a sitting or squatting position." The force of gravity augments the woman's natural uterine contractions, usually reducing the time needed for delivery. Compared to the usual hour to 90 minutes spent in second-stage labor by women delivering horizontally, those using the chair at Lenox Hill average only 30 minutes. "It took only three pushes," says New York mother Eleanor Dyette.

Because of its molded contours, the chair gives a woman something to push against and takes pressure off the back, thus reducing the pains that often follow conventional childbirth. It also decreases the risk of blood clots in the legs. And many women simply enjoy the psychological benefits of delivering from a seated position. "When you're supine, you feel vulnerable," says Gail Kaufman of New York. "In the chair, you feel more in control."

The chair raises a few objections from obstetricians. For example, it allows less room to maneuver forceps. But doctors like Nash are enthusiastic. "It's embarrassing for us doctors in 1981 to finally learn what nature told us many years ago," he says. "Most of womankind will give birth in the vertical position if there's no interfering physician to make them lie down."

MATT CLARK with MARIANA GOSNELL

Giving Surgeons An Extra Arm

They can cut out tumors, sew up cuts and help in coronary-bypass surgery. They give physical examinations, write prescriptions and soothe anxious patients and their relatives. But they have never gone to medical school; some have never finished college. Their job: surgeon's assistant.

Surgeon's assistants form the elite corps of a growing class of health professionals called physician's assistants—their skills falling between those of a technician and a doctor. Since Duke University opened the first training program for physician's assistants in 1965, more than 15,000 PA's have been graduated nationwide, including about 3,000 of the specialized surgeon's assistants. "SA's give the physician an extra arm," says New York heart surgeon William A. Gay Jr. Patients and their families appreciate the SA's just as much. "A lot of things came up that weren't important enough to disturb the doctor," says Rose Reed, whose mother was a cancer patient in Birmingham, Ala. "But I could call Sherri [SA Sherri Wade]. When you get somebody who cares and is available, it's just wonderful."

It's not easy to become a surgeon's assistant. Most candidates begin by taking the physician's assistant course and then move into surgery through either apprenticeship to a practicing physician or a postgraduate hospital internship. But some choose to train in surgery from the start. Cornell University screens as many as 500 applications each year for fifteen slots in its training course. Many already have professional health-care experience, often as nurses or physical therapists; some have college degrees in the sciences. Perhaps the most important prerequisite is an understanding of the position's limitations. The University of Alabama at Birmingham almost automatically rejects anyone who confesses an ambition to become a physician. "Being an SA is not a steppingstone to becoming a doctor," cautions Dr. Peter Dineen, director of Cornell's program. "It's a separate and distinct career."

Responsible: Nonetheless, the two-year SA training regimen resembles a pared-down version of medical school. After six months of intensive classroom work in the sciences, the trainees move into the operating room for practical training. After graduation, SA's work with a "preceptor," a licensed physician who is professionally and legally responsible for their performance (SA's are covered by the doctor's own malpractice insurance). The SA may carry out many of the procedures the preceptor does—with his permission—from ordering diagnostic tests to removing stitches. "Under the law, I can take off a mole or sew up a laceration," says SA Betty Epstein, assistant to a plastic surgeon at Cornell. But SA's are encouraged to refuse any request they think is beyond their ability.

Some SA's—who start at about $20,000 a year and can earn up to $50,000—work for surgeons in private practice. They can keep the doctor's office hours if he is op-