HISTORY AND DEVELOPMENT OF MODERN OBSTETRIC NURSING WITH SPECIAL EMPHASIS ON THE PUBLIC HEALTH PHASE

V.

Ruth Geraldean Sammons

"For every child full preparation for his
birth, his mother receiving prenatal, natal
and postnatal care, and the establishment
of such protective measures as will make
child-bearing safer."

-- A Standard Set Up in Childrens'
Charter of White House Conference

INTRODUCTION

Having made a study of the history and developments of obstetric nursing, I am endeavoring to set forth some of the trends that maternity care has followed and the present status in different countries, particularly Great Britain and the United States.

In the art of obstetrics, which is as old as mankind, we have come a long way, and many a milestone and obstacle has been met and passed along the way. From the earliest times, when women went off by themselves to deliver or were accompanied only by a woman companion, to the marvelously-equipped lying-in hospitals with all their asepsis, modern equipment, specialized obstetrical nurses, and the well educated and prepared obstetrician of today, has been a long journey. The trend of obstetrics has been toward recognition of the fact that, although reproduction is a physiological process, much can be done to aid both mother and child before, during and after birth, which will bring about a healthier and stronger race.

The term, "Obstetrics", derived from the Latin word meaning "to stand in front of" as a midwife stood or knelt before her patient on the birth stool, originally signified the assistance afforded a woman in labor. In its modern significance, it includes physiology and pathology of conception, gestation, parturition and the puerperium with all complications and pathological consequences of the child-bearing act at all periods.

The concept of Maternity Care has grown from mere attendance and medical care at the time of delivery with a few days rest in bed following delivery to supervision, care and help from beginning of pregnancy on through a period of at least six weeks follow-

ing labor, with the ideal program extending this care for one year after the birth of the baby.

HISTORY OF MIDWIFERY

Broadly speaking, the history of obstetrics, which necessarily is that of midwifery, may be divided into three periods: ancient, or female midwifery; modern, or male midwifery, and a period of transition between which covers the period from the first quarter of the 16th Century through the first quarter of the 18th Century.

In this ancient period, on occasion, the primitive medicine man, or ancient physician, was called to aid the midwife, but usually the parturient was attended by midwife alone. Then came the golden age in Greek medicine when the physician began to give some attention to this branch of the healing art, doubtless because his skill was not unfrequently demanded by the midwife in desperate cases, although there is no positive evidence that he was ever called primarily to take charge of a case of labor. However, a study of medical literature shows that even with this apparent interest by the Greeks, until the 16th Century, the subject of obstetrics received little, if any, attention from medical authors. At this time, as I have mentioned above, the period of transition begins.

According to Joseph L. Miller in his treatise on "Renaissance Midwifery -- The Evolution of Modern Obstetrics", 1500 to 1700, this transition falls into three divisions: (1) The instruction and improvement of the midwives by reviving for their guidance the best of the knowledge of the old Greek writers; (2) the attempt of surgeons to increase their own knowledge of the female pelvic anatomy and to improve the procedures to be followed by them when called to assist the midwives in seriously complicated cases and, (3) the gradual intrusion of educated male obstetricians into this

branch of medical practice, and the study of the pregnant woman.

With the dawn of the 18th Century, we find the beginning of modern obstetrics. Since this time, obstetrics has advanced to a more scientific position than ever before, the mechanism of labor has been established and natural labor defined.

From remote ages, as I have said before, midwifery has been the special province of women, never in times past, a part of medicine, nor of nursing but occupying a place of its own. Their position and requirements doubtless rose and fell with the general position of women. But, however, notable their position might have been, it is known that the most dreadful ignorance and superstition controlled much of their fundamental services to motherhood.

The qualifications of the early midwife were mainly what she learned from her own experience; probably she learned something from sister midwives, but aside from these two sources, there was not much opportunity for her to improve her skill. Literature offered her but little help even if she could read. The oldest text book for midwives appeared under Hadrian (A.D. 117 to 138). These were not followed by others and no advances were made in the education and practice of the midwives until the 16th Century. The greatest impulse to the progress of midwifery was given in the middle of the 16th Century by the famous French surgeon, Ambrose Paré, with his treatise on midwifery.

From the 16th Century to the present time, there has been an increasing interest in midwifery on the part of the medical profession, and physicians have come to participate more and more in the care of the parturient woman. However, in most European countries, and in the East, this participation has supplemented the midwife rather than replaced her and in none of these countries today does a physician attend as many as 50 percent of the con-

finements, with the exception of Scotland. In many countries, he attends less than 10 percent.

In the 17th Century, some women who had large experience in midwifery appeared as authors, among them, Jane Thorp in England, Justine Siegmund in Germany, and Louise Bourgeois in France. In the early part of the 19th Century, Madame Le Chapelle, another noted French midwife, made some contributions to the literature on midwifery.

In Continental Europe, toward the close of the 17th Century, special schools were instituted for proper training, though it was not until well into the 19th Century that any supervision or regulation was imposed on those who acted as midwives. Today, all countries of Europe have standards for midwife education, either national or provincial. They are required to undergo a course of thorough training, and practice is carefully regulated by legislation, though it is different in the different countries. Some countries have both state and private schools, others have state schools only, and in others, all schools must be approved by the state. A midwife must complete a course of training varying from six months to three years. In France, final examinations must be given only by the medical department of a university. In Denmark, where the instruction is carried on as a part of the maternity hospital service, the midwives are taught by doctors, nurses and midwives, and the teaching is under direct supervision of two professors of obstetrics from the state medical school.

For the most part, in European countries, midwives are taught and permitted by law to attend only normal cases of delivery, but there are exceptions to this. Public control is by regulations pertaining to licenses, birth and other reports; records of work, disease notification, requirements for calling a physician in com-

plicated emergencies; punishment for malpractice or violation of the regulations, and in some places by supervisory visits. There is no provision for inspection of midwife's patients by physicians except in cases of complications following delivery. England, alone, did not have a law governing midwifery and its practices until 1902.

The history of the British practice of midwifery in past centuries shows that parturient women have more usually been cared for by women than by surgeons or physicians. A committee of the London Obstetrical Society in an inquiry made by them in 1869, found that from 50 to 90 percent of the total births were attended by midwives, a proportion not dissimilar from the present proportion with the important difference that most midwives are now qualified for their work and this work is carefully supervised.

However, in the past, the type of midwife in England has been much the same as that in other countries, and it was not until 1902 that the Midwives Act was passed through Parliament -- an Act to secure the better training of midwives and to regulate their practice. This Act forbade any woman to use the title of midwife after April 1, 1905, unless certified to do so under the Act. After April 1, 1910, it was enacted that, "No woman shall habitually and for gain attend women in childbirth otherwise than under the direction of a qualified medical practitioner unless she is certified under this Act". Existing midwives, who hold a midwifery certificate, or who without this, produced satisfactory evidence that they "had been for at least one year in bona-fide practice as a midwife" were allowed to be certified as midwives.

A central Midwives' Board for England and Wales was formed to administer this Act. The rules made by this Board must be

approved by the Minister of Health. The councils of counties and county boroughs were appointed local supervising authorities, and every midwife is required to report her intention to practice in an area to its local supervising authority. Midwifery inspectors are appointed by these authorities to visit midwives, inspect their records and outfits, give them friendly advice, warn them in respect to irregularities in their practice, and to investigate complaints of malpractice or cases in which a discharge from the infant's eyes has been reported.

In the United States, the physician has superseded the midwife as an attendant, but has not excluded her. Some states do not license or control the midwife, while others have made provisions for licensing and controlling and still others only require them to register. According to the report on "Obstetric Education" by the committee on prenatal and maternal care at the White House Conference, the number of midwives in the different states ranges from none in Nevada and Iowa to 5000 in North Carolina. A few states did not reply to the questionnaire; while Nebraska claims not to have a midwife problem; has no provision for licensing them, nor do they feel that there is any likelihood of such being necessary. In this same report it gives as the reason for the variety and low educational requirements in most states, the lack of opportunities for midwife training in the United States. At the time this was written in 1931, there were but two schools, one being the Bellvue School for Midwives, established in 1911 in New York City, the first school ever to be established in America, and the other in Philadelphia.

Realizing the uselessness of laws and regulations that require the midwife to have a course in a recognized school of midwifery when there are no schools available, many states have set

up practical requirements which fit the local situation. Most of the midwives who have had a formal course of training, providing both theoretical and practical instruction, are graduates of foreign schools. Such graduates are found among the white midwives; with the exception of a few nurses who have had a course of midwifery training, most of the Negro midwives are uneducated.

In general, statistics by states where midwives practice show very favorable maternal mortality rates in their practice and remarkably low rates for the mothers attended by trained and supervised midwives.

Keeping in mind the statement that the doctors have superseded the midwife as an attendant, the question arises as to whether or not there is a need or demand for midwives in the United States. In answer to this question, the Committee on Obstretic Education of the White House Conference found that as nearly as can be estimated, there are approximately 47,000 women in this country who act in the capacity of midwives; only a small proportion of them are trained women; some of them attend only one or two cases a year, but others have a large practice. Altogether, nearly 15 percent of the births in the United States are delivered by midwives and others who are not physicians. By states, the percentage of births attended by midwives varies from none in some states to between 40 and 50 percent in others. In general, the states with the highest percentage of midwife deliveries are the southern states with their large Negro population. For the most part, the midwives who serve the Negro population are untrained women. These people have to use untrained midwives because trained ones are not available, and physicians frequently cannot be afforded, even if they are available. The Negro midwives have shown themselves eager and willing to avail themselves of such

educational advantages as have been offered to them in the way of theoretical class instruction by state boards of health.

The problem is not confined entirely to the Negro population; in many states, midwives attend large numbers of white women at confinement. The reasons for this vary. Custom, sparseness of the population and scarcity of physicians in some states, and economic conditions all play a part. As one state health officer in a sparsely settled south-western state said in speaking of the situation in his state -- "We must accept the midwife and attempt gradually to improve her practice. Fewness of physicians and distance people live from them make it impossible for a large part of the population to employ them, because they are not to be had at any price and because people cannot pay the fees. A trip of 100 miles at a dollar a mile, plus regular obstretic fee, would consume more than the entire cash income of a family for a year in many cases. The midwife in this state is an institution dating from prehistoric times. Any attempt to curtail her activities arouses a storm of protest from the Spanish-speaking population which comprises about one-half of the total".

In 1931, after considering all the data which had been collected in a study of the midwife situation, the committee on Obstetric Education of the White House Conference, paying particular attention to needs in certain sections of the country, made the following recommendations:

1. The ultimate solution of the problem of good obstetrics is in developing a sufficient number of physicians who are well trained in the fundamental principles of obstetrics. The development of such physicians is a direct responsibility of the medical schools.

2. At the present time, the midwife is a necessity; and

every effort should be made by the profession to improve her as rapidly as possible. This improvement should be brought about by local effort. Inasmuch as the midwifery need seems greatest in those states in which the economic status is low, aid is needed and would hasten the relief of present conditions.

3. Recognized institutions for the training of midwives, which would assure preliminary education and proper training must be established if present conditions are to be improved permanently. The establishment of such institutions is a local responsibility. They should be located in sections needing the services of midwives and where they will not conflict with the obstetric teaching work of medical schools. It is felt that midwives trained in or near their own communities will be more likely to stay in those communities where their services are needed.

4. Inasmuch as the need for midwives seems greatest in those communities having a large Negro population, it would seem wise to establish institutions for the proper training of Negro midwives in the South where a wealth of controllable clinical material is available.

5. There should be provision for postgraduate courses for keeping midwives up to date.

6. The Committee commends the good work that has been done in recent years by many state boards of health and feels that such work should be continued under the same supervision.

7. The Committee appeals to the individual state boards of health to develop standards for midwife educations, supervision and control. Such standards would regulate the requirements for licensure and insure adequate supervision by obstetricians, qualified midwives, and public health nurses with midwifery training. These problems are local and can best be solved by local

administration.

8. It is suggested that midwifery training would offer the Negro trained nurse a larger field of activity.

In the same year, The Association for the Promotion and Standardization of Midwifery was incorporated, representative of national interests in the midwife problem,

In 1932 a training school for midwives was organized by this Association as a memorial to Ralph Waldo Lobenstine, M.D. Under the leadership of Mrs. E. Marshal Field, it was financed for a three-year period by a group of sixty women. The course in midwifery covers a period of ten months. The first four months includes instruction, supervision, and practice in the general field of public health nursing with special emphasis on supervision. This work is given under the supervision of the Department of Nursing Education, Teachers College, Columbia University. The remaining six months in midwifery includes: lectures and demonstrations by obstetricians and nurse-midwives, observation and instruction in cooperating maternity hospitals, observation of as many confinements as possible, and the responsibility for the prenatal, delivery, and postpartum care of as many cases as are available under the supervision of the resident obstetrician or certified nurse-midwife.

The practice field for the student midwives is affiliated with The Lobenstine Midwifery Clinic, Inc. The clinic is located in a congested district in the city of New York where the birth rate is high, where poverty is common, and where the customs of the people favor the services of midwives. The clinic patient is given a careful medical examination and if found to be normal, free from disease, and without a contracted pelvis, she is assigned to the midwife service for home confinement with the understanding

that the prenatal, delivery, and postpartum care is given by the midwife under medical supervision. The patient who is found by medical examination to have abnormal conditions is referred to cooperating maternity hospitals for care.

The requirements for admission to the course are: four years of high school or an accepted equivalent, the diploma of an accredited school of nursing, registration in one of the States of the United States, and two years of professional experience, one of which has been spent with a recognized public health organization. The applicant must be eligible for university matriculation. Exceptions to these requirements will be made for applicants whose professional accomplishments justify special consideration and for those who are referred by organizations which are training local personnel for midwife supervisors.

Preference will be given to applicants from states where the practice of midwifery is more common and where the individual applicant has the endorsement of the State Health Commissioner or Director of the Bureau of Child Hygiene.

Following is a progress report on the work of the Association on the three-year project in midwifery for the year 1932:

"Most of the time and funds for the first nine months of 1932 were devoted to the organization and development of the outdoor maternity service. The development of this type of clinic service for the purpose of educating nurse-midwives necessitated the re-education of the social, nursing, medical, and health agencies in the Clinic district. The community reactions to the idea of the "nurse-midwife" and "midwifery clinic" presented a problem, the overcoming of which is both expensive, time-consuming and resulted in slow growth of the Clinic. In September, 1932, the first class of nurse-midwives was admitted. The applications for the course

were numerous, and it was comparatively easy to select students who had had rather broad professional experience and who were eligible for college matriculation. There are seven students in the first class, five on scholarships, two on part scholarships; each one is going to a midwifery position when she finishes the course. The students either through scholarships or personal funds are responsible for the full cost of the course including tuition, board, room, laundry, and incidentals.

The fundamental idea in the clinic service and in the school is that nurse-midwives are to be educated to assume the responsibility for normal midwifery under the supervision and direction of competent medical authority.

Careful records of the experience of the school and the clinic are being kept and will be reported on from time to time. Before the certificate of the school is awarded, the nurse-midwife must have demonstrated her practical ability as a midwife and she must successfully pass a comprehensive written examination, and an hour's oral examination given by the Board of Medical Examiners. The doctors and the nurses who have assumed the responsibility for this project which may tend to revolutionize our present-day methods of obstetric care, believe that obstetric nursing, public health nursing, and midwifery must be combined.

The most obvious prerequisite to the development of nurse-midwifery is the creation of an attitude of acceptance on the part of doctors, nurses, and lay people alike, of the nurse-midwife as an important factor in providing adequate maternity care. The future of the nurse-midwife in the United States depends upon her ability as a citizen and a professional worker to create opportunities for her services and to develop proper professional standards for her practice."

This report was prepared by Hattie Honeschemeyer, Executive Secretary of the Association for the Promotion and Standardization of Midwifery, Inc., for the Committee on Relation of Nursing to Maternal Care of the National League of Nursing Education, in the year 1933.

Before leaving the midwife problem, I want to present an account of the work being done by the graduate nurse-midwives of the Frontier Nursing Service in Kentucky, their set-up, and educational requirements.

This nursing service was first organized in 1925 by Mrs. Mary Breckinridge with the counsel of doctors and experts in public health and the backing of the Kentucky State Board of Health. She formed this organization to provide educated nurse-midwives; to work in cooperation with nearest medical and public health authorities; to deliver women in childbirth and safeguard the lives of little children; to care for sick of all ages and take measures to prevent disease; and to work for economic conditions less inimical to health. She began in Leslie County in the very heart of the mountains. Since her purpose was to work through the people and not for them, she began by organizing a strong local committee of leading mountaineers; then, with their cooperation, she opened her first nursing center, herself, and two educated nurse-midwives in charge, at Hyden, the county seat of Leslie County. Their work is divided into three parts -- midwifery, general care of families and prevention -- midwifery taking first place.

In 1932 there were 8 centers and 31 nurse-midwives including Mrs. Breckenridge. At the center in Hyden, there is a hospital with 18 beds, a babies' ward, dispensary, a small operating room, a little wing for infective diseases, and a resident doctor to

direct the work. This is an indispensable medical center for the work, for in outlying stations, cases frequently arise that cannot be handled without a doctor and hospital care. The work is now financed mostly from outside, but they care for the families at a rate of $1.00 per year per cabin full, to be paid in any way possible.

Maternity work is still the primary concern, but this leads on to family care, disease prevention and social service work of all kinds. They hold summer clinics, give diphtheria immunization, vaccination for smallpox and answer emergencies of all sorts. The nurses are always ready to ride, having two saddle bags -- one side for general work and one side for deliveries. The response of the people is nothing short of miraculous. As to the success of the work, one cannot help but marvel at it. Up to December, 1931, the service had delivered over a thousand women in the district with the loss of only one mother in childbirth, and she was a hookworm cardiac. One other eighteen-day postpartum mother with mitral stenosis died in the hospital. Most deliveries come in the winter months or early spring. Their motto is, "If the father can get the nurse, the nurse will get to the mother".

The following educational preparation is necessary before one can enter the service. Each American woman must first have her complete hospital education in this country and so become a graduate nurse. Then, for six months, she is tried in Kentucky, and if found acceptable, she is sent to England or Scotland for midwifery education. After getting her license, she returns to America for a course in public health work unless she has already had it here. Only after all this is she at last enrolled as a Frontier Nurse. Many of the nurses are Scotch or English and took their training oversea. Mrs. Breckinridge, the director, is a graduate of

St. Luke's Hospital in New York; spent several years nursing in France; took her midwifery training at British Hospital for Mothers and Babies in London; supplemented this by a first-hand study of work of famous Queen's Nurses in English and Scottish Highlands, and then took the English Central Midwives Board examination to secure her license as a midwife.

My next step in the preparation of this paper is to consider the nurse who does obstetrical nursing -- her present work; her preparation, and her relation to the physician.

In portraying the origin and development of the obstetrical nurse, I feel that I cannot do better than to quote a paragraph or two from the address which Dr. Geo. W. Kosmak, then Editor of the American Journal of Obstetrics and Gynecology, gave at the Thirty-ninth Annual Convention of the National League of Nursing Education in 1933.

"There is no branch of medicine in which the services of the nurse have come to be considered so essential as in obstetrics. From time immemorial women in labor have felt the need of those ministrations in their hours of trial which only the skill and sympathy of another woman could supply. And in the course of time, when it was felt that practical assistance was needed as well as sympathy, the introduction of the midwife may be looked upon merely as a further development of these more simple functions. Nurse and midwife were synonymous terms for several centuries, and then there came a period when the care of those afflicted with illness and injuries in general developed into a profession, the beginnings of which may be related to the appearance on the scene of Florence Nightingale and her successors during the middle of the last century. After this the midwife and nurse again resumed their respective vocations, especially in European

countries. However, special methods were found advisable for training women in obstetric nursing per se, either as assistants to doctors, or to carry out certain specific work in maternal and infant welfare activities, and, in countries where midwife practice was finally superseded by that of the physician, the trained nurse, as we know her, was given definite instruction in obstetrics to enable her to take on those functions which could not be properly carried out by the doctor."

In the obstetric practice of Europe, the nurse is a small factor as most of the nursing care is furnished by midwives who also perform the functions at delivery, which in the majority of cases, are assumed by the physician in this country. The midwife carries on the work of both physician and nurse, in which she has been well trained in most of the European countries, and conducts the labors in varying percentages running as high as eighty-five in some countries.

In the United States, the physician does not give the nursing care, as a rule, though he often prepares the patient for delivery and gives the necessary and immediate postpartum care. He is not trained to give nursing care, and he could not give the time and energy necessary even if he were so inclined. The nurse, on the other hand, is not educated to give the care and attention which is given by the midwife and the physician.

The work of the trained nurse who, as we know her, is largely an American institution, is closely related to that of the physician, and is almost entirely under his supervision and direction. She does not attempt to diagnose or prescribe, but refers the patient to her family physician; or, in cases where she does not have a family physician, she is referred to a clinic.

In the past, the maternity nurse, as a rule, has had no

preparation further than that which she received during her service spent on the obstetrical floor while in training. However, through experience and desire to do so, we have had many good nurses in this line.

Today, it is the opinion of most doctors and others in the field of obstetrics that the maternity nurse should have special preparation for her work, as there are various functions to be performed which require more or less specialized education. The maternity nurse needs to be well trained as a physician's obstetric assistant, and she should know nursing techniques so well that she is able to carry out all the nursing care during pregnancy, labor, and the puerperium which will contribute to the safety and comfort of both mother and infant during the postnatal period. This means that she must be able to work as the physician's assistant in the office and in the patient's home. As a public health nurse, she must be able to instruct the mother concerning prenatal, natal, postnatal and postpartum care; aid the doctor at time of delivery when the patient is allowed to deliver at home, and carry on infant welfare work. Or, it may be that she will assume duties as a nurse in charge of a maternity ward, pavilion, or hospital, or she may have special functions in a maternity hospital, such as being in charge of the labor rooms, or she may develop into an executive, or into a teacher.

It is unnecessary, and probably impossible, for any one nurse to acquire all the functions of maternity care in relation to private duty nursing in the home and in the hospital, institutional nursing, public health maternity nursing, and work with a physician as his obstetric assistant. There is need for nurses who are trained in each one of these various fields of endeavor.

I could go on to tell the special preparation for each type

of work in the maternity field, and the opportunity and need for each. But, as my particular interests lie in the field of public health and public responsibility for adequate maternal care, it is primarily my intention to consider the public health phase of maternity nursing in the remainder of my paper.

It has been only in most recent times that prenatal care and supervision has been stressed and carried on to any great extent. Most women and their husbands, particularly among the lower classes, feeling that the childbearing act is a physiological and natural process, could not realize the need and necessity for such care. Many times, the doctor is not consulted until labor begins or until complications develop during labor. The postpartum care has not been considered a necessity, either. These factors have loomed up as two of the greatest causes of maternal and infant mortality. However, through education and information for the public, much has been done in bringing the importance of such care before pregnant women. By arranging clinic care for those who could not afford a private physician, much suffering and many deaths have been averted.

The public health nurse in her work should be given much credit for her part in helping to bring about such a vast improvement. Public health nursing was first started in Liverpool in 1859 by a Mr. Rathbone. Having had occasion to have a nurse in his home, he became so enthusiastic about her work that he asked her to undertake, as an experiment, the care of the poor in their homes for three months. From this humble beginning, public health nursing has grown until it now includes much more than merely giving care to the sick poor in their homes.

A large part of any public health nursing program will necessarily be given over to maternity care as this is one of largest

and most important fields.

The ultimate purpose of the preparation of a nurse for public health work in maternal and infant welfare is to fit her (1) to supplement the physician's work in the care of the pregnant woman and her unborn baby; (2) to assist the physician at the confinement, or, in his absence, see the mother and baby safely through; (3) to care for and guide the mother until she has completely recovered from the effects of childbirth.

After having read considerable material on education of the nurse, it is my opinion that most educators, doctors and others in the field of obstetrics feel that student nurses enter maternity departments or hospitals unprepared for the experience they are about to meet. The reason for this seems to be that the pressing needs of schools of nursing and hospital work necessitates the assignment of the students to this division of practical work too early. The student, then handicapped, fails to benefit fully by the opportunities offered.

For this and other reasons, graduate students are not ready for an advanced course in obstetrics. A thorough preparation in almost every branch of nursing is necessary to the nurse who expects to specialize in maternity work and infant care. No public health nurse, although her special interest may be the mother and infant, can avoid taking responsibility for the health and the happiness of all who make up the home. The whole community is her field.

There is also a question in the minds of many as to whether a student should be given her obstetric experience as an undergraduate. If her education in obstetric nursing is given at this time, it should not begin before the third year, when she has already had her surgical experience and most of the other founda-

tion work. The first two and a half months of this undergraduate experience should be under close supervision in the hospital. Theory and practice should be related so closely that every bedside is virtually a classroom.

The field of choice for the students' preparation is a maternity hospital having an active in-service and out-service, with prenatal, delivery and postnatal services closely cooperating with other public health work. Sufficient time should be allowed the nurse to become familiar with all phases of mother and infant care. Her training should not be superficial or hurried. Opportunity for supervised reading and study is essential.

The guidance of obstetricians, who are our best teachers, can only be gained through close cooperation. Such guidance is necessary if the subject is to be kept on a high plane. Careless obstetric practice is not inspiring. Unscientific infant care is most discouraging in its results. Sympathetic, enthusiastic teachers and instructors who know the work are needed, though not readily found. Nor are they being prepared in sufficient numbers.

The close observation and care of many mothers and infants, and the intensive personal instruction given in the delivery room are necessary before the student nurse can benefit by experience in clinics and in homes, where she must learn to safeguard mother and baby without the aid of the hospital's equipment and personnel.

In four months a student should have gained an insight into obstetric nursing, although a much longer time is necessary to make of herself an efficient public health nurse in obstetric work and infant care.

Following is an account of some of the public health set-ups for obstetric work which are found throughout the United States:

MATERNITY CENTER ASSOCIATION, NEW YORK, N. Y. -- This Association

was first organized in 1918 in answer to the war cry for saving infant life and is now widely known. It is set up in the ensuing manner:

It is an incorporated association with both an official medical and nursing advisory board. Dr. George W. Kosmak, editor of the American Journal of Obstetrics and Gynecology, is chairman of the Medical Advisory Board; Miss Hazel Corbin is General Director of the Association, and Miss Louise Zabriske is Field Director and thus carries on the supervision of the nurses in the field. There are twelve graduate nurses, each with special preparation in addition to the general director, field supervisor and office staff. All medical supervision and work is carried on by doctors from New York Lying-in Hospital. Affiliation with the New York Lying-in Hospital was made in 1932, and the director of nursing service at the hospital is hired primarily by Maternity Center.

The real work in this Association is done by the nurses and it is essentially a nursing Association. Work is divided into three phases: prenatal, delivery, postpartum and postnatal care.

Prenatal Care

Maternity Center Association has a room set aside for their work at the New York Lying-in Hospital. Mothers' classes are conducted here routinely for mothers in the Maternity Center District, instruction being given by a nurse from the Association. The nurse takes a full prenatal history at this time, and this takes the place of a home visit. The only actual home visits which the nurses make are referred to them by the hospital. Here, as at all outlying clinics, there is a nurse who does the instructing and interviewing of the mothers, and a nurse who keeps the records. The record of work done in the field by Maternity Center Association is transferred to the records of the New York Lying-in Hospital.

The nurse may find patients in the district and direct them to the hospital for registration and examination which is given by a hospital doctor. The prenatal care is then given alternately by the hospital and Maternity Center Association under close supervision of the hospital.

At their field center, the Association still holds one doctor's clinic for prenatal work, carrying only those patients who have had their initial examination at the New York Lying-in Hospital and expect to deliver at home. The patients must live in Maternity Center District. They also conduct mothers' classes at this field center. This prenatal clinic is conducted by the New York Lying-in Hospital, their doctors giving the examinations and their technique being followed though the nursing service is given by the Maternity Center Association.

Natal, Postnatal and Postpartum Care

Maternity Center nurses are called on all home deliveries conducted by the New York Lying-in Hospital in their district, these deliveries being conducted by interns and medical students. If enough student nurses from the New York Hospital are available, they are also taken on the home delivery, the supervision being given by the nurse.

Postpartum and postnatal care is given by Maternity Center nurses under supervision of the Hospital doctors and the patient is directed to the New York Lying-in Hospital for postpartum examination and infant welfare clinics.

Next is the Maternity Program as it is carried out by the University of Oregon Medical School -- Out-Patient Department. The chief objectives of this department are, the care of the mother, the teaching of medical students, the teaching of graduate nurses taking the Public Health Course, and research. From the standpoint

of the Medical School, the first objective is the teaching of the medical student, then research, then the care of the indigent sick.

The staff consists of a Chief of Staff; a Clinical Instructor in Obstetrics; three Resident Doctors who alternate on Gynecology and Obstetrics, two on Obstetrics and one on Gynecology; a Director of Maternity Nursing and a post partum nurse.

Ante partum and Prenatal Program

The patients are referred to the clinic by the Visiting Nurse Association, the Family Relief Unit, the private physicians, friends and patients themselves.

There are four prenatal clinics, two at the Out Patient Department at the Medical School and two in the district at branch libraries.

When a mother registers she is sent to the laboratory where a routine hematology, Wassermann, and urinalysis is taken, then to our clinic where her temperature, pulse and respiration are taken and recorded by a nurse. The Senior Medical Student then takes her history and gives a complete physical examination which is checked by the Resident or Attending Staff Doctor or the Instructor. General instructions and when to return to the clinic are given by the Doctor and Student. The mother is also given a list of prenatal instructions.

On her return visits, which are every three weeks during the first seven months of pregnancy and every week during the last two months, the patient consults with the Resident. Abdominal examinations for position, fetal heart tones, height of fundus, are made at regular intervals. If the Wasserman report is returned positive, the patient is advised of the report and urged to attend the luetic clinic promptly and regularly for treatments.

As soon as possible after a mother registers with us, a nurse calls on her in her own home. We make but one contact visit unless

the Resident requests a call because of toxemia, or other complications of pregnancy.

A very important part of our ante partum program is the Mother's Classes which are conducted every week in our district clinics.

Intra partum and Intra natal Program

The majority of our patients are delivered at the Multnomah County Hospital. A few deliver at Emanuel Hospital, paying $35.00 cash which includes Doctor's service, and hospitalization. A copy of the mother's chart is sent to Emanuel Hospital before her delivery. Some patients who are approved by the Residents deliver at home. The home delivery preparation is demonstrated to the mother in her home.

On a home delivery, a Resident Doctor, the post partum nurse, and two senior medical students attend. The patient is delivered by the student under close supervision of the Doctor. Post partum care is given by the Visiting Nurse Association, if in the city limits; if outside, it is given by the County Nurse. The records as made by the students are filed in the Obstetrical office in order that the doctor and nurse may also follow the case.

Post partum and Post natal Progress

When the mother leaves the hospital with her baby, she is given an appointment to return to the post partum clinic when her baby is about six weeks old; she is also given a list of post partum instructions, as well as an appointment to bring her baby to the Infant Hygiene clinic.

The Infant Hygiene Program is carried on by one baby clinic a week at the Out Patient Department. Mothers are referred to the Visiting Nurse's Well Baby Stations in their localities, the V.N.A. referring them back to us for any pathological conditions. Babies

are registered from a few days old up to two years of age and monthly visits are made to the clinic and oftener if the doctor orders it. The Infant Hygiene Clinic is under the supervision of the Chief of the Staff of the Doernbecher Hospital.

The above clinic program is set up along the lines of the Maternity Center Association, New York, N. Y.

Other means for maternity care are provided by Visiting Nurse Associations, County Health Associations and other public health set-ups, throughout the United States.

"Maternity care should be the same the world over; whether the mother lives in the city or in the country, in a palace or in a hut, she needs medical and nursing supervision, care and instruction during pregnancy, an aseptic delivery under the direction of a skilled obstetrician, and medical and nursing supervision, care and instruction until after she is able to resume her regular responsibilities and to care for her baby. Physical surroundings and the attitude of mind of the patient and her family may differ, but the actual care of the mother should be the same." Such was the statement made by Dr. George W. Kosmak, chairman of a committee appointed to study the preparation of the obstetric nurse for her profession today.

In the United States, we stand today, as a nation, where we stood twenty years ago, with a maternal mortality rate that is admittedly three times as high as it should be, even as it could be if the knowledge we have about the needs of the maternity patient were applied in the care of every mother. We stand at the top of a list of the civilized countries with the highest maternal mortality rate.

Good medical and nursing care in home or hospital are only part of all that is necessary to make maternity safe. They are

not enough without sufficient food of the right kind, adequate rest and recreation, and help with such social and economic problems as family maladjustments, distorted mental attitudes, habitual emotional disturbances, inadequate incomes and anything else which interferes with the normal progress of pregnancy, labor and puerperium. And such care is far beyond the power of the individual family to provide for itself. It requires that coordination of all the health, social and recreational resources of the community which will best meet the needs of each individual patient.

Some feel that a remedy for the high maternal mortality rate would be in developing a midwife program, and it may be that the present European system of midwife and physician is yielding better statistical results in reference to maternal mortality, but the obstetrician can do for his patient things which contribute to her future welfare, and the well educated and properly trained nurse can give care and attention which the midwife cannot supply. As a forward-looking program, the close cooperation of nurses and physicians, working in their respective fields, probably can supplant the European midwife system to the advantage of both mother and infant, and to all concerned.

The present facilities and methods of educating and training obstetric nurses do not meet these needs, and steps should be taken to remedy this situation.

In order to learn how much nurses really know about maternity care, the Committee on Nursing Education of the White House Conference undertook to secure this information by submitting two questions to several groups of nurses. These were as follows: (1) State what you consider constitutes complete care for a mother from the beginning of pregnancy until the baby is six weeks old, and (2) How can maternal mortality be prevented? The groups of

nurses selected included private duty nurses, recent graduates taking the State Board examinations, and nurses taking post-graduate courses in public health nursing. Sixteen hundred and twenty-two nurses returned answers to these questions, and while this group represents a very small proportion of all the nurses in the United States doing obstetric nursing, it may be regarded as fairly representative of the whole number. Taking it all in all, the replies were rather unsatisfactory. The Committee felt that there was no escape from the conclusion that nurses as a class are not fully appreciative of what adequate maternity care means. The answers seem to reveal very little understanding of the value and significance of the individual procedures employed in obstetric practice. The question about preventing mortality was not answered at all by a discouragingly large proportion of these nurses. As a matter of fact, few of them replied in a way to indicate that they had any real knowledge of the causes of maternal mortality or of the means of reducing it.

The preventability factor in obstetric practice has been shown by careful studies to be a large one; estimates vary from forty to sixty per cent, which means that the high puerperal mortality of this country is a national problem challenging all the obstetric attendants, not only physicians but nurses and health workers who come into contact with pregnant women. A significant fact brought out by these questions was that nurses taking postgraduate courses in public health nursing answered the questions better than the other groups, and that private duty nurses did better than the new graduates, -- in other words, practical experience counted.

A postgraduate course, well and generously planned, will allow time for more advanced study and experience. The post-graduate student should be relieved of most of the routine bedside

care so that she may devote her entire time to the study of the patient. The nurse should enter as a student to study and to be taught, rather than to give nursing care.

What part the nurse will take in the supervision, care and instruction of patients, will differ in many communities. Just what it will be in any given instance will depend on the available medical and nursing facilities, and on the division of labor between the physician and the nurse. Of course, certain parts of the care must be given by the physician and under no circumstances can these be delegated to the nurse, no matter how complete is her knowledge of obstetric nursing or even of midwifery.

In an ideal program, the nurse's duties may include any or all of the following:

1. Finding mothers early in pregnancy, teaching them their need for medical care during pregnancy and persuading them to go to a physician.

2. Instruction during pregnancy in:

a. The mother's hygiene, nutrition, rest, exercise, elimination, bathing, clothes, care of breasts, care of teeth, and how this hygiene may be fitted into the daily routine of the home.

b. The preparation for the baby, including clothes, bed, toilet supplies and the care of them.

c. The preparation of delivery supplies and a plan for the mother's care when the baby comes and during the next few weeks.

d. The care of the baby, including bath, rest, exercise, food, habit formation and how the best daily routine may be secured without disrupting the family life.

3. Observing and questioning the mother to learn about symptoms and discomforts needing attention, including simple urinalysis and measuring the systolic blood pressure.

4. Studying the mother's home surroundings and family relationships so as to discover, and help to solve, any problem which in any may may disturb her peace of mind.

5. Considering the health of every member of the family, teaching the fundamentals of personal and home hygiene and arranging for health examinations, the correction of defects, the following of treatments or advice.

6. Helping the doctor or midwife during delivery.

7. Giving, or teaching some responsible person to give the necessary care to mother and baby during the days that follow.

8. Keeping the doctor or hospital informed by sending a detailed report on each visit, including findings and advice.

The nurse should see to it that the household is running smoothly, so that the mother can rest as long as necessary and resume her usual activities and increased responsibilities gradually and as the physician advises. Then, when the mother begins to care for her baby, the nurse should be there to explain again all those points, each so important, that the mother has been taught in classes. She should help the mother to plan her day's work, so that she can have time for rest and other things and still give the baby the best of care.

Before the nurse stops visiting, she should make sure of four things: first, that the mother has seen per physician for the last examination that is so necessary to detect and correct, at once, any bad effects of the pregnancy; second, that the mother has a copy of the baby's birth certificate and understands the reasons for keeping it with her important papers; third, that the baby is registered with a physician or a clinic for regular health supervision and instruction until he goes to school; and, finally, that father and mother recognize that "an ounce of prevention is worth

a pound of cure, " and that regular health examination for the whole family is that ounce of prevention which will reduce the amount of sickness to a minimum.

As a final conclusion to my paper I am presenting a standard curriculum as set up by the National League of Nursing Education for the obstetric education of the nurse in the hospital, in 1932, and some of the recommendations made by the Committee on Obstetric Education of the white House Conference, for improving obstetric education and as a possible means of lowering our high maternal mortality rate.

League Curriculum

This curriculum includes thirty hours of theoretical instruction in obstetric nursing, ten hours of lectures by an obstetrician, and twenty hours of classes by a nurse who knows teaching methods and obstetric nursing. These lectures are planned to give the student nurse an intelligent background for understnading the reasons for the care and the treatments prescribed. The classes are planned for discussion of the lectures and of the "how" and "why" of the nursing procedures pertaining thereto. For instance, after the lecture on the physiology and hygiene of normal pregnancy, come two classes discussing the supervision and care of pregnant mothers and the details of prenatal nursing.

The practical experience outlined in the curriculum covers three months in a special obstetric department of a general hospital or in an affiliated maternity hospital, and includes the nursing care of normal and of operative cases, and of normal and of premature babies. The minimum experience stated as commonly required is the observation of 12 cases during labor and delivery, the student assisting in not less than 10 deliveries. Experience in antepartum and postpartum clinics, and a month in out-patient work, when this is available, under careful supervision is stated to be highly desirable.

The League curriculum states that heads of departments should be prepared to teach their specialties, and all who instruct or supervise nurses

should not only know their subjects but have experience and training in teaching.

Some of the Recomendations Made to White House Conference
by Committee on Obstetric Education

1. That the White House Conference be asked to appoint a committee on teaching obstetric nursing and to supply funds for its work.

2. That this committee be asked to consider:

Studying the preparation in obstetric nursing in those countries where it is considered a postgraduate subject and comparing it with our present method.

Preparing a fundamental curriculym for theoretical instruction and practical experience in obstetric nursing that will be sufficient to teach nurses what adequate maternity care is and how to give the nursing part of it from the beginning of pregnancy through the puerperium.

Preparing a plan for securing the approval and gradual adoption of the curriculum by schools of nursing throughout the country.

3. That the committee recommended above be asked to consider also the preparation of a curriculum for a true postgraduate course in obstetric nursing and of a plan for securing at least one such course.

4. That a subcommittee of the committee suggested be formed to study the best way to prepare,control, employ and supervise attendants for maternity work. Suggested type of personnel was also suggested.

6. That these conditions affecting unfavorably the teaching of obstetric nursing and the apparent ignorance among nurses doing obstetric nursing, be discussed with the executive secretaty of the National League of Nursing Education, and a plan be made for calling the situation to the attention of hospital trustees, medical boards, superintendents and directors of nursing, with a formal request from the White House Conference that they arrange to give nurses a better preparation for helping in the maternity care that is needed to reduce maternal mortality:

By improving obstetric service in accordance with the Standards for Maternity Care, prepared jointly by the Committee on Maternity Care of the Children's Welfare Federation and A Committee Appointed by the New York Obstetrical Society.

By using graduate nurses and attendants, not student nurses, where the volume of service and facilities for teaching are inadequate.

By improving, by a program of staff education, the qualifications of the nurses now teaching and supervising in the obstetric departments.

By employing graduate nurses to do some of the nursing so that the stucents may be freer to make the most of their education.

By making the prerequisite for admission to the school four years of high school.

By planning for all students, as soon as possible, practical experience which shall include antepartum and postpartum clinics (with home follow-up as assistant to the prematal of social service nurse), general nursing care of bed patients in maternity wards , of babies in nurseries, of at least 20 patients in labor and during delivery, delivering one or more patients under supervision, work in outpatient department or visiting nurse association doing prenatal, delivery and postpartum work under good

supervision so that the students can learn to adapt teachin to home conditions while still being taught.

By giving the theoretical instruction outlined in the League Curriculum.

7. That hospital trustees, medical boards, superintendents and directors of nursing be urged to accept as stucents those graduate nurses who wish to make up for the deficiencies in their elementary instruction in obstetric nursing or to keep informed of changes and developments in obstetric procedures.

I have omitted giving more recommendations which were made, feeling that the above are sufficient to show the trend of desired obstetric education and care, and the objectives for which it is striving.

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