VII. ADVANCE IN MATERNITY CARE

Doris Hayes

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PREFACE

Maternity health is important to the nation and so very important to our progress in the future. Upon maternal health depends the health of the nation. By gaining the maximum maternal health, the nation will have the cornerstone laid for almost all preventive medicine--a healthy mother, a healthy baby and consequently a healthy nation.

"There is probably no industrial occupation for which women cannot qualify, but they have a more important calling. By virtue of a divine function coupled with human intelligence they have the power of giving or withholding the life of nations.

This is God's supreme commission. Man is woman's great work. Cell on cell she builds him up and delivers him to the world at the risk of her life. His survival depends upon her sacrifice, and God gave her mother love to make that sacrifice a joy. During his infancy she nourishes him at her breast. This service is its own reward. Life holds nothing half so sweet. Did you ever see a mother look down at her nursing baby? He is her treasure. He is the hope to which she has dedicated her life. Throughout his childhood she guards him and cares for him according to her light, and if he dies love's labor is lost and her heart is buried with him. But when he lives and grows and his mind unfolds, and he finally reaches man's estate, this is the consummation of her great work--the fulfillment of the law of love and life. Did you ever see a mother look up at her son? He is her finished product. He is her gift to the world."

Esther Lovejoy

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HISTORIC BACKGROUND OF MATERNITY CARE

Chapter I

The care of women in childbirth dates back to the earliest stages of history. From the very dawn of mankind's existance on earth, the pregnant woman has been familiar with the agonies of labor. "I will greatly multiply thy pain and thy travail; in pain shalt thou bring forth children" has originated from the Biblical story of the temptation of Eve and her partaking of the forbidden fruit. How woman has provided for the travail of labor, and how she has delivered is a fascinating story throughout the ages.

We are able to study childbirth among the primitives not only from fragmentary records, but a more recent knowledgh of their present day practices. Civilization has had little or no effect upon primitive tribes and their customs, religious believes, folklore, and superstitions have remained the same because they have been rigidly followed.

Childbirth to the primitive man was tied up intimately with religious convictions, but was restricted by the peculiar moral customs in their feeling of modesty and shame.

The Egyptians began to record events about 5000 B.C. The first records of childbirth are found in hieroglyphics in the valley of the Nile. Demons and all types of mystic beings are pictured here. Priests and priest physicians play an important part, and it seems that little or no dependency is placed upon

the human being. This was the time when mysticism controlled the thoughts of man and there was much superstition because of fear and ignorance. Supernatural powers have exercised a controlling influence over childbirth, some to aid and some to hinder, but all playing an important role in matters pertaining to the welfare of the mother and child.[1]

Because of the primitive man's continued strife with elements, fear was early engendered in him. Naturally he turned to the medicine man or priest whom he believed possessed supernatural power, and wisdom in dispelling the demons. It may be said that the priest commercialized on these superstitious beliefs. Toward such ancient quacks the expectant mother, realizing her dependance, looked for solace and inspiration in seeking the ministry of supernatural powers. Many and varied have been the means employed to frighten away the ghosts and demons that haunt pregnant women.

The childbirth of the primitive woman was generally easy because of her healthy and natural mode of life. Their freedom from all the exciting and exacting influences of civilization tended to fit these primitive women both physically and temperamentally for childbearing. Her diet was vigerous. She was likely to have a strong, adequate pelvis. She had no emotional or nervous states, and was not a neurotic. Her outdoor life, hard work, and constant use of muscles kept her robust. Some of the ease of childbirth of the primitive was the result of mating with men and women of the same tribes. Breeding amongst races often causes the foetus to be too large for the woman's birth canal.

It was customary even among primitives for an expectant mother to go to a place of retirement on the eve of delivery. In some primitive tribes the confinement took place in public and became sort of a spectacle in which young and old were enabled to satisfy their curiosity. These public lyings-ins were the exception rather than the rule. Normally the woman gave birth quietly and with decent privacy. She went off into the woods or some other secluded spot either alone or with a small group of attendants. Sometimes tribal regulation demanded of the pregnant woman that she retire to a spot at a stated distance from the settlement. Just as the woman was frequently banished from the village limits during the period of her menstrual flow, she might also be placed apart from her community during her confinement. The edict arose from a strange regard for taboos. She was considered impure at the time by some tribes, others thought the evil spirit had entered her soul. But with retirement both in menstruation and labor the woman was afforded a period of rest and a temporary release from her domestic occupation.[2]

To these primitive confinement places women retired with one or more friends to assist in delivery. The observations of the processes of birth led to efforts to quicken the period of its duration. Sometimes these efforts were undertaken a month or more before the expected delivery. In some tribes an attempt was made to spread the mouth of the uterus, beginning a month before delivery. The moistened leaves of a plant were rolled together tightly into a cone and insert-

ed into the mouth of the uterus for the purpose of distending it. More generally used was a bandage around the abdomen. This procedure is used today. In primitive time it was used to force the foetus downward and to hasten its delivery. The precaution was taken to keep the foetus from rising higher in the abdomen.

Manipulations and massagings were used to force the child down and to correct any slight abnormalities of position. The assistant was able to tell by feeling the abdomen whether the child was in correct position for delivery. If it was not, compression and massage were attempted to alter the position and hasten delivery.

The position of women in giving birth were many and varied. Every conceivable attitude was assumed. Even today the modern woman when gripped with agonizing pain assumes the squatting or kneeling position of the savage. The standing position is peculiar to many uncivilized races. It may be found to be a practice among the Hindu tribes, and tribes of central Africa and the Philippine Islands. A suspended position is also common. Some swing from a limb of a tree. In Mexico the attendant lifts the patient and lets her fall. This procedure is repeated in an effort to shake the baby out. In some places when the desired result is not produced, the midwife induces her dirty hand and pulls upon whatever she may find. Sitting upon stumps of trees, stones, or the ground is a favorite position among many tribes. So many things were done to expell the child--even going so far as

to jump upon the abdomen of the pregnant woman.[3]

The function of the chief assistant in childbirth was to receive the newly born infant, to assist in drawing it out and to sever the umbilical cord. The other assistants busied themselves with massaging the woman, chanting encouragement and incantations or administering brews and herbs.

Medicines were given for several purposes. Often they were given to test the vigor of the child. If it was a weakling it would not be able to withstand the strong doses given to the mother and only the more fitting would survive. Or the bitter medicine might make the child want to leave the mother. Medicines were also used to increase the parturient's pains and exertions to speed the delivery of the child. Others were used to relieve pain. All sorts of fantastic concoctions were prepared to hasten delivery and to appease hostile devils.

The primitive woman was frequently restricted in the food she ate, both immediately before and sometimes after she ate. Sometimes the women abstained from food for a time before birth of the baby in an attempt to warn the child that it was no longer to depend on the mother for sustenance. Generally good diet was followed after childbirth. She was first placed on broths and easily digested foods before she indulged in heavier meals. Mixtures of teas and concoctions of herbs were usually given after labor agonies.

The customs of bringing on the afterbirth and disposal of the placenta were as varied as any part of the childbirth

rituals. The usual custom was to bury the placenta, or burn it so as to make its whereabouts unknown.

Changes in childbirth came about early in the history of civilization, but this process was gradual and was constantly relapsing by ignorance and religious taboos. To this day there are a large number of primitive hangovers. For some time the Greeks had quite rational manipulations for childbirth although they were crude in comparison to those of today. However, their methods took a relapse and it was sometime before science came to the aid of the suffering mother.

Egyptian midwives attended deliveries and lying-in, some only to sing and chant incantations, others to lend manual help in the delivery of the woman. If the delivery became difficult priests might be called to ease the pain by their magical formulas. If the life of the mother was dispaired by prolonged labor, the foetus was cut and extracted in pieces.

Among the ancient Hebrews, the suffering that the women in labor had to do was given a devine sanction. The hebrew woman was for the most part robust and strongly built and underwent delivery without assistance. There is some record, however, of midwives. Postnatal customs were rigidly adhered to. This involved a long ritual of purification. The ancient Hebrews tabooed abortions. The mother of a large family was admired, and there was veneration for the pregnant woman.

Soranus as early as 220 B.C. made many valuable contributions to obstetrics. The vaginal speculum are indeed not new. Soranus introduced the speculum and obstetrical stool. He con-

doned all such practices as pummeling the abomen, inducing labor, and many mystic practices. He practiced only the gentlest handling of the pregnant woman. He knew that both the woman or the man may be responsible f or sterility, and that the most favorable time for conseption is just after the cessation of the menstral flow. The following are the qualifications that he gave of a good midwife, and well may they be followed today.

"She should have a good memory, be ambitious and stick to her job, be of moral conduct that she may be trusted; she must show good sense and be of strong constitution. Finally she must have long, delicate fingers with short trimmed nails. In order to be a good midwife, a woman must have still other good qualities. She must have theoretical and practical education in all fields of the healing art, as she is expected to give advice concerning diet, and also surgical and pharmaceutical directions. She must be observing in order to have a correct judgment about the connection between the single sumptoms of the art. It is her duty to encourage the suffering woman, to help her, to be fearless in all dangers, and she must give her advice in a quiet manner. Further, she must be respectable and cautious and very discreet, as she is participating in many secrets of life. She must not be covetous of money,neither can she be superstitious. She must see to it that her hands are tender and soft and avoid work that would make them hard. But if by nature her hands are hard, she has to use salves in order to give them softness."

The Greeks also highly honored the mother, and their practices in medicine were very good. The Greek woman lived a healthy outdoor life. Her dress was in keeping with her pregnancy. She was well attended with midwives who helped her in prenatal and delivery. These women were those usually who had undergone motherhood themselves and were also trained in methods to facilitate the labors of the parturient. She also knew femine anatomy fairly well. The Greeks approved of abortions, and in some cases encouraged it. Abortions were done by the midwives. Generally, the midwives attended all labors, but a

male physician might be called especially for difficult cases. They were seldom called unless the midwives, after attempting their traditional methods to produce the desired results. The cases attended by the physicians were usually those in which the child was not in the normal vertex position. An effort would be made to manipulate the body from the outside so that the correct position for delivery might be obtained. If this was not successful, the Greek doctor would be called in to do a podalic version. Podalic version was known in these ancient times. The general postion of the child was discovered by a manual examination of the abdomen. If the child was in an abnormal position, the hand was inserted into the uterus, the feet of the child grasp and turned. However, this procedure was probably carried out infrequently because the active lives of these women would bring the child into normal position.[4]

The Roman procedure of childbirth, as in many of the Roman customs was a copy from the Greeks. The woman was quite highly respected. However, childbirth was not held with the highest esteem. The women submitted to numerous abortions.

It was at the time of the fall of the Roman Empire that obstetrical knowledge began to lag. Midwives began to assume charge of pregnancy, and they were no longer as skilled or as clean as those of the Greeks and Roman centuries. The church with its direction of other worldliness became the substitute for the more advanced knowledge of Soranus. The belief of the church developed shame for the human body and emphasis was layed upon the soul. These conceptions became so strong that the entire act of childbirth was effected by it.

mental mind. Obstetrics can be said to really be advancing from this period on without relapse to the old superstitions. This progress of the knowledge of childbirth was the result of many men in different directions, observation, and study. Anatomical knowledge was probably of first importance. The knowledge of anatomy at first was very inaccurate, but as observations were made with more precision, there was an increasing skill in child delivery, both medically and surgically. Medical interest was awakened, and problem of pueperal fever, difficult labors and sex complications were discussed. Studies were published, guides were given to midwives, and lying-in hospitals were established.

Eucharius Rosselin wrote a book dealing with obstetrical knowledge. He himself had had little experience in midwifery. His book consists mostly of a collection of standard authorities and scraps of information. Even though his book could not be said to be authentic, it contained enough to make it of importance in obstetrics. It was really the beginning of an obstetrical encyclopedia and was the starter of much obstetrical literature.[5]

Andreas Vessalius the sixteenth centuries greatest anatomist contributed greatly to the obstetrical art. He did dissections of the human cadaver. Studies were made of the female organs and many long-standing superstitions and fears were allayed.

Several difficulties were present in the medical profession at this time that held up progress. One was the prevailing attitude held by the physicians toward the surgeons.

There was good reason for this because surgery lacked the modern aids of anaesthesia, aseptic techniques, and blood control methods, and was truly a brutal occupation. The hog-gelder, and the barber surgeon were ignorant and brutal. A change was brought about however, by Ambroise Pare.[6] He was originally a barber apprentice, but later bacame a student at the Paris hospital, the Hotel Dieu. He became fairly skilled. In his writings on surgery, he also included a section devoted to obstetrics and lying-ins. He included information on the anatomical and medical nature of the reproductive parts and gave instructions to midwives and physicians on care during labor. It was also at this time that the Caesarean section was performed, and not as a legend. It was recommended in cases of complicated pregnancy.

It was in the Hotel Dieu that the most famous obstetricians of the seventeenth century carried on his practice, Francoise Mauriceau. He believed in the theory of nature as a healing power and he stemmed the trend toward instrumental aid and too frequent manipulations by the surgeon. Mauriceau wrote a monumental work on gynecology and obstetrics, and his work gave further impetus to continued study and research.[7]

It was at this time that the forceps were used in obstetrics and they may well be said to have had a grand stage entrance. The Chamberlin family of England, who were obstetricians hit on the idea of forceps. For decades they guarded the device as private. Hugh Chamberlin realizing its value desired to sell it at a high figure. He went to Mauriceau, who was not in sympathy with the new aid to obstetrics.

Chamberlin tried his instrument on a dwarfed, malformed woman who was in such a condition because of rachitac malformation. Not realizing that these instruments had limitations, his demonstration had a fatal end. However, after improvements on the instrument, it has proved of importance in the obstetrical world.[8]

France at this time was far ahead of the other countries of Europe. As France continued to develop, other countries lagged far behind. These countries were inferior in medical and surgical aid, and much of the obstetrical care was in the hands of incompetent midwives.

After the use of the forceps and the growing popularity of obstetrical surgeons, there became a growing rivalry between surgeons and midwives. Midwives wrote pamphlets and made many statements indeed not in favor of the male attendant. But this antagonism between midwives and surgeons was of benefit. It challenged the midwives to raise their standards and improve their activities. As a result of these disputes between midwives and surgeons, there was an encreasing public interest which spurred the medical profession to give more concern to gynocology and obstetrics. The sufferings of women were accepted as a part of medicine, and many advances were made.

Lying-in hospitals were one of the progressive steps in the eighteenth century. They provided assistance to the impoverished mother and brought expert knowledge to the aid of the abnormal case in delivery. However, the hospital as

a maternity ward had its blackened reputation. This came as pueperal fever. It attained such an alarming degree that it was considered as a pestilence. In 1773, the fever raged with special severity throughout the countries of Europe. Entire wards of pregnant women died after childbirth.

Oliver Wendell Holmes was the first to make men understand the transmission of infection to the mother. He drew attention to doctors as carriers of the disease to the lying-in wards from other patients. Ignaz Semmelweis experiminted and found that if doctors washed in a disinfectant before delivering the child that the mortality from pueperal fever was highly reduced. Later Louis Pasteur demonstrated the possibility of contagion. It remained for men like Lister to develop methods of antisepsis and later asepsis. Many other progresses in the field of medical research were a great aid to childbearing women--anesthesia, medicinal and surgical treatment. So from this period on, we may say that maternity care is on the upward move, although at times it seems very slow in progress.

1. Findley--Story of Childbirth, Philadelphia:Lea Brothers and Company, 1905, page 1

2 Rongy, Abraham, Childbirth Yesterday and Today, New York: Emerson Books Inc., 1937, Chapter I , page 17

3 Ibid, Chapter I, page 21-23

4 Ibid, Chapter II, page 37

5 Ibid, Chapter III, page 44

6 Ibid, Chapter III, page 52

7 Ibid, Chapter III, page 55

8 Ibid, Chapter III, page 59

THE MIDWIFE

Chapter 11

Very little has been said in the proceeding brief history of maternity care about the midwife. She had played a very important role on the stage of obstetrics for her institution is almost as old as motherhood itself. In the very earliest times she was a close friend or relative of the pregnant woman, and aided her as best she could with her limited experience. Later it became more of a profession and the midwife claimed to possess a superior skill. Midwives have existed everywhere from the darkest parts of Africa to the frozen North. From primitive times to our present day, midwives have played many different roles--some of high importance and some of lowly rank. Just what her future will be is questionable. She has gone through vicissitude and changes of fortune, through history, and whether she finds a place in our modern civilization remains for time to tell.

There is little actual record of midwives in early times. We are lead to believe their care was all that was given to the pregnant woman for reason of the belief that the body of the woman should not be seen by male attendants. The pregnant woman also was often considered unclean at time of birth, so she was given little consideration. However, as has been stated before, childbirth to the primitive woman

had few complications, and in many cases she did not need assistance. In early history when we find some record of the midwife, she is found to have been ignorant, and charms and incantations were her methods of procedure. She was without skill and knowledge. Sometimes midwives called on the expert aid of priest or physician who often were even a greater ménace. In India, the foetus was often cut up in long labors, only to cause injury to the mother and possible death. Midwifery at this time was highly dramatized by superstitions, and methods of procedure--such as incantations, concoctions and potions.

"Midwivery in ancient Greece was an established profession with a recognized status not only among the general population but with physicians as well. The duties of the midwives extended, in fact, far beyond the assistance at the time of delivery. They also advised on the health and care of the female genital organs. They sold love potions. They carried on a trade in contraceptives. They freely induced abortions. They advised on the physical compatibility of couples contemplating marriage and gave out sex information and hints to lovers. All in all, they were a sort of mother confessor to the Greek woman in matters affecting sex. This gave them a high standing in the community: so much so that Plato quotes a favorite simile of Socrates, who referred to himself as a midwife to bring out the truth."[1]

The midwives of ancient times were not all ignorant or socially debased. Some were of high social order and women of intelligence and skill. Even Aristotle speaks of their wisdom and intelligence.

During Greek history, midwives were respected and were allowed to practice without let or hindrance. However, they were required to meet requirements of high standard. Moschion states these requirements. "Midwives had to be literate, intelligent, of good memory, thoughtful, active, strong, without physical malformation or infirmity, sober, modest, prudent, not avaricious, and past the stage of coquetry."

The Greek midwife not only had charge during the delivery, but also cared for the mother postnatal and postpartum.

The Roman midwives' procedures of lying-in were almost identical with those of the Greeks. The occupation of midwifery was varied. Rome at the time of the height of its imperial city was filled with lust and sexual vice so that much of the time of the midwife was filled with catering to inordinate sexuality.

As has been stated before throughout the Middle Ages European culture was dominated, and in all the dark period obstetrics lanquished. The midwife was in demand because the Church forbade presence of a man at birth. She was in sole command of obstetrics and was unequal to her responsibilities, because of her ignorance and inability. The high standards of Greece lapsed and the midwife at this time had no virtueous qualities and aquired what little skill she had in training on women in labor. Much has been written of the ignorance and immorality of the midwives in France during the sixteenth century. Because of the malpractise of Madame la Lepere, the doctors, priests, lawyers, and Jesuits joined together to put an end to the criminal practice of midwives. The first lay laws regulating the practice of midwives were issued in France in 1560. At the time Mauriceau practiced midwifery, midwives trained in Hotel Dieu under the supervision of Mauriceau and men like him. They were vastly superior to those who apprentices to town matrons, and they were also superior to the midwives of other nations.

France was the country in which midwives achieved their greatest distinction as obstetric here was far ahead, but midwives played important roles in Germany and Great Britain.

There seems to be little record of midwives in Germany prior to the thirteenth century.. It was as early as 1339 that the first lying-in hospital was established in Murnburg hospital in Germany, but it was not until the sixteenth century that they had laws governing the practice of midwives.[2] These were national laws. At first no license and no instructions were required, but later the midwives were under strict supervision and were held accountable for their actions. Physicians were abandoned from obstetrical practice as late as 1532.

The State formulated definite rules regarding midwives.

> "The midwife was admonished to remain sober, to be temperate in all things, to live a godly life, to be conscientious and to lend encouragement to the mother. She was not permitted to baptize the infant except in unusual circumstances. All instruments and other necessary accessories were prescribed; the midwife could not refuse to give her service; she was required to call a physicial or one of the "honorable women" in time of need; the birth of illegitimate children must be reported to the authorities of the town or Church; the greatest care must be given to the mother and child; and to perfect herself in her duties she must be studeous and receive instructions from physicians."[3]

Midwives had little chance of gaining a reading knowledge of obstetrics before the eighteenth century because all obstetrical literature was printed only in Latin. The English midwife not only became famous for her achievement in her profession, but also because of literary ability which led them to publish pamphlets and books on their art. There was much contention between the male in the lying-in chamber and

the midwife. The midwife wrote many pamphlets knocking the physician and surgeon. However, this only lead the public to realize the true state of the situation, and the full force of obstetrical progress was mainly brought about by male surgeons. Midwives were required to pass an examination. Many famous midwives wrote books of instruction. Midwives were urged to become educated in their art and take long courses of apprenticeships. Real progress was made. Schools for midwives were established, and it became customary to call in male obstetricians in difficult labor.

Dr. William Smellie did much in the reform of English midwives although he was the bunt of many of their pamphlets. He observed the brutal management of difficult labors in the hands of midwives. He gives excellent qualifications for a midwife: "A midwife, though she can hardly be supposed mistress of all these qualifications, ought to be a decent sensible woman of middle age, able to bear fatigue; she ought to be perfectly well instructed with regard to the bones of the pelvis, with all the contained parts, comprehending those that are subservient to generation; she ought to be well skilled in the method of touching pregnant women, and know in what manner the womb stretches, together with the situation of all the abdominal viscera; she ought to be perfectly mistress of the art of examination in time of labor together with all the different kinds of labor, whether natural or prenatural, and the methods of delivering the placenta; she ought to live in friendship with other women of the same profession, contending with them in nothing but knowledge, sobriety, diligence and patience; she ought to avoid all reflections upon men-practitioners; and when she finds herself at a loss, candidly have recourse to their assistance. On the other hand, this confidence ought to be encouraged by the man. When called, instead of openly condemning her method of practice (even though it should be erroneous), he ought to make allowance for the weakness of the sex, and rectify what is amiss, without exposing the mistakes. This conduct will effectually conduce to the welfare of the patient, and operate as a silent rebuke upon the conviction of the midwife; who, finding herself treated so tenderly, will be more apt to call for necessary assistance on future occasions,

and to consider the accoucheur as a man of honor and a real friend. These gentle methods will prevent that mutual calumny and abuse which too often prevail among the male and female practitioners; and rebound to the advantage of both; for no accoucheur is so perfect but that he may err sometimes; and on such occasions he must expect to meet with retaliation from those midwives whom he may have roughly used."

Today midwives in England are highly educated in their art, only officiate at normal deliveries and always call in competent obstetricians in cases of any abnormality.

This brief history shows to us how for ages the midwife dominated midwifery in the European countries. She has been given little credit for her efforts and much abuse. They were ignorant and they were superstitious, but at this, in comparison to other professions, we must realize they were not the only ones with shortcomings. She should be accorded a place of distinction. She was an arbitrator of the lying-in room, and visited the hovels of the poor and the palaces of the rich.

1 Rongy, Abraham, Childbirth Yesterday and Today, New York: Emerson Books Incl, 1937, Chap., page 76

2 Findley, Palmer, Story of Childbirth, Philadelphia: Lea Brothers and Company, 1905, Chapter I, page 327

3 Ibid, page 330

DEVELOPMENT OF OBSTETRICS IN THE UNITED STATES

Chapter III

Benjamin Rush tells us that among the North American Indians in the early history of our country, nature was their only midwife; that the Indian woman often gave birth without the assistance on one of their sex. Dr. Rush states they were fortunate in escaping the services of incompetent midwifes.

Midwives were probably the first to practice obstetrics in America, and were undoubtedly those who had previously practiced in England and European continent. Many towns in the New England states which were without service of a midwife extended invitations to those practicing elsewhere. These midwives were held with rather high esteem; however, sometimes they were accused of witchcraft and being possessed of the devil.

The midwives were quite busy. Women at this time had large families even to twenty-six children are recorded. Records also show that the maternity and infant mortality was great probably as the result of such large families.

In Manhattan, the first obstetrical attendants were known as "The Ziekenstroosters".[1] They were women trained as nurses and cared for all the sick, and also unfortunately for maternity cases. However, this was not satisfactory and mid-

wives took their place. During the seventeenth and eighteenth century, the practice of obstetrics was mostly in the hands of women. Early in the eighteenth century they passed an ordance for midwives. "It is ordained that no woman within this corporation shall exercise the employment of midwife until she hath taken oath before the Mayor, Recorder or an Alderman to the following effect. That she will be diligent and ready to help any woman in labor, whether poor or rich; that in time of necessity she will not forsake the poor woman and go to the rich; that she will not cause or suffer any woman to name or put any other father to the child, but only him which is the very true father thereof, indeed, according to the utmost of her power; that she will not suffer any woman to pretend to be delivered of a child who is not indeed, neither to claim any other woman's child for her own; that who will not suffer any woman's child to be murdered or hurt; and as often as she shall see in peril or jeopardy either in the mother or child, she will call in other midwives for council; that she will not administer any medicine to produce miscarriage; that she will not enforce a woman to give more for her services than is right; that she will not collude to keep secret the birth of a child; will be of good behavior; will not conceal the birth of bastards, etc."

Obstetrical records in the southern colonies were almost identical with those of the north. Dr. W.E. Blanton states that until the knowledge of antisepsis and causes of pueperal sepsis were known, the midwife was perhaps safer than the obstetrician. The obstetrician was apt to make manual examination before delivery, and thus introduce an infection where as the midwife waited for the birth. Dr. W.A. Plecher, of Virginia Bureau of Vital Statistics was able to show by available statistics that death from pueperal sepsis was greater among the white race attended by doctors than among the negroes attended by midwives.

The obstetrical practice in the colonies may be said to be a mirror reflection of obstetrical practice in England. As has been stated it was almost entirely in the hands of

women, and only in the most unusual cases were men called in. It was not until the invention of the forceps that the art of obstetrics received any attention by medical men. It was not until the middle of the eighteenth century that it was accorded a place in the practice of medicine. So the forceps may be said to have started a general advance in obstetrics.

Dr. John Moultrie, of South Carolina was among the earliest obstetricians and was held in high esteem. The first public teacher in this country was Dr. William Shippen of Philadelphia, also about the same time Dr. John V.B. Tennent gave instructions in New York. Largely due to these men, obstetrics found its place as a regular branch of medical education.[2] So we see at the beginning of the nineteenth century, obstetrics really coming into its own. Now one wonders just what part the midwife will play in advancing obstetrical knowledge and skill. This topic as such will be discussed in a later chapter.

[1] Thoms, Herbert, Chapters in American Obstetrics, Springfiedld, Ill., D. C. Thomas, 1933, Chapter I, page 7

[2] Ibid, chapter I, page 17

MATERNITY MORTALITY AND MORBIDITY

Chapter IV

It seems as far along as civilization has come and the advances made in obstetrics many problems exist in maternal welfare. The United States has an unenviable record of having one of the highest maternal death rates in comparison with countries of the same cultural and economical rank. Of course statistical reports vary in countries, but the fact is not altered that we loose too many women in childbirth.

Maternal mortality should be defined before any statistical reports are given. "Maternity mortality includes all maternal deaths ascribed to causes incident to maternity--in a particular population or group during a stated period of time."[1] This means that maternal mortality does include all deaths of women during the maternal cycle which are due to conditions arising from the maternal state alone--that is when no other possible cause of death exists.

The problems of, or to make a positive statement, the prevention of maternal mortality involves three major factors: 1. the attendant, including obstetrical attendant, medical, midwife, or lay person, 2. the pregnant woman, 3. and the community.

It must be realized that there are physical deviations from the normal, pathological and abnormal physical dev-

elopment due to unexplainable and unknown reasons. A certain number of deaths that can not be classed as a cause of neglect of any part of society. But here we are dealing with the preventable causes and from what portals of entrance we can approach for the best maternal care.

Several studies have been made on statistical reports of causes of maternity mortality and methods of prevention. Of these are Maternal Mortality in Fifteen States, conducted by the U.S. Children's Bureau Publication No.223 1934; Maternal Mortality in New York City--A study of All Puerperal Deaths 1930-1932, The Commonwealth Fund 1933; Maternal Mortality in Philadelphia, 1931-1933--Philadelphia County Medical Society Committee on Maternal Welfare.

The New York study is the most crystallized study made. There has been a careful analysis of all the deaths reported as a result of childbirth. All facts connected with the patient were carefully investigated--physicians and midwives were interviewed, hospital records examined. However, the committee did not feel the report too accurate as there are so many intangible factors associated with maternal mortality. This study lasted over a period of three years and included 2041 deaths 1343 or 65.4 percent of these women might have been saved. "That number of women, if they had had proper treatment and care, could have been brought safely through parturition. Behind this <u>if</u> stands all those elements of economic status, education, professional skill, professional honor, competence in judgment, competence in performance, and good sense which renders all performances and behavior so very variable and unpredictable."[2]

Of these 1343 deaths, 61.1 percent were charged to the

medical profession, 36.7 percent the patients themselves, and 2.2 percent to the midwives.

The medical attendant is the important figure in obstetrical care today. He reaps reward, but is also bearer of much grief when death wins. "He who all the honor upon him, too, falls all the blame." Included among the 820 deaths ascribed to physicians of New York City study are 369 in which the death of the patient resulted from errors of judgment; 382 deaths were errors of technique; 69 of the 820 deaths were due to abortion and were not included.[3] All the deaths that could have been avoided had been brought about by some incapacity in the attending physician: lack of judgment, lack of skill, or carelessness and inattention to the demand of the case. Errors in judgment occur in all human undertakings. Errors in technique could be better met as is reported by the New York City report.

"It has been repeatedly asserted that medical schools do not now provide sufficient training in normal obstetrics. That they must do. But they have a further obligation: to inform the student that the training which he receives does not qualify him to practice as a specialist in obstetrics. His training is to enable him to conduct normal labors and to be able to recognize and evaluate the abnormalities requiring the services of a specially qualified obstetrician. The medical profession must insist that prolonged graduate study is necessary for specialization. So important is this element that it might be advisable to set up a legal barrier preventing any but those who had shown themselves specially qualified from doing any operative obstetrics.

If such education is to be demanded of the practitioner of medicine, facilities for obtaining it must be made available. Such facilities are strikingly lacking today. The graduate in medicine who wishes to further his study of any specialty meets with the greatest difficulty in doing so. Hospitals must be prepared to receive these men as internes in order that they may have the opportunity of using clinical material. Medical schools should offer courses to the practitioner."

If courses are offered and specialists are to be developed, there must be some way in which the public can inform itself as to the status of any given physician. Obstetrical societies or other qualified groups could prepare such lists, admitting candidates who had satisfactorily demonstrated their qualifications by examination. These lists should be made available to the public at request and the knowledge of their availability widely distributed.

With the establishment of such requirements for specialists, certain other correlative requirements will appear. If the practitioner is to confine his activities in obstetrics to normal deliveries, far more consultation will be required. Earlier and more frequent consultation with the highly trained specialist should be more freely resorted to. It must be made clear that consultation with the most highly trained specialists is always available to any patient for a minimum or nominal fee where circumstances demand it."

Slightly less than 30 percent of all the deliveries studied took place in women's homes. There are 900 midwives in New York City and they attend almost 10 percent of the annual births. Some of these were interviewed, and most of them were found to be incompetent. However, their results compared well with that of the physician. The committee decided that the midwife should have a position in the scheme for providing maternity care and that the medical profession should find that position.

The committee dealt no less severely upon the patient who is responsible for one third of the preventable deaths. These patients are grouped into two classes; those who failed to obtain suitable care because of ignorance or neglect, and those who refused to cooperate with the attendants. According to the New York report more than a third of all preventable deaths were due to some failure on the part of the patient herself to take advantage of those facilities which are at hand for safeguarding her in the period of gestation

and lying-in. This element in the situation is one of education entirely. For many women pregnancy is of such frequent occurrence that they cannot regard it as a condition meriting any special consideration. One uncomplicated delivery may lead a woman falsely to suppose that subsequent pregnancies are without hazards instead of being, perhaps, potentially more hazardious. She is unaware of the grave possibilities which arise with pregnancy, and the pressure of maintaining the home at its usual level is so great that her problems are prone to be disregarded. Education is to instil the knowledge that with proper care during pregnancy and labor much of the discomfort and many, if not most, of the dangers of childbearing can be removed, has quite simply failed to reach these women. It must be constantly renewed and persistently maintained to have its full effect in altering the present situation. Furthermore, mere education to obtain care will not suffice. The lay public must know what constitutes proper care so that there may be discrimination in the choice of attendants. It must be borne in mind that in many, if not most, instances where the patient has been held responsible, we recognize that she is, in fact, helpless by reason of circumstances which are not of her making and lie outside of her control. She may be, and very often is, the victim of poverty or ignorance and, in such eventualities, it is manifestly the failure of society to provide proper and effective education, assistance, and care which have forced her, unwittingly and surely unwillingly, to become the de-

ciding factor in her own death. Clearly, it is only those patients who have wilfully failed to obtain care and follow the advice given by their attendants, who can justly be held responsible for the outcome. There is still a great tendency to omit prenatal care. Careful, persistent education is required to produce in the less educated and less fortunate women of the city an attitude which will make prenatal care an accepted necessity. It seems that the large amount of propaganda and effort already put forth has failed to produce the desired results. Too often the woman goes to the clinic only to register for delivery and then fails to return regularly. The 40.8 percent of the cases ascribed to lack of cooperation on the part of the patient include many cases of this type. One visit to the clinic, and then no further contact until labor sets in or there is some symptom so alarming that it cannot be disregarded is, for too often the rule in these cases.

The community may be held responsible for much of the inadequate care of mothers. They either do not see the need for medical care or are ignorant of the need. So education of the community is an important factor in maternal mortality and morbidity.

One of the great causitive factors for maternal mortality and morbidity is the so-called proprietary hospitals. They are usually privately run and for a profit. The medical care is usually not supervised and/is controlled by incompetent medical authority. They are the direct opposite of

our well-organized hospitals.

Abortion is also an important cause of maternal mortality and morbidity. It has been estimated in some parts of the United States that the number of criminal abortions equal the number of children born. A conservative figure has been set at 17,000 annual deaths from criminal abortions. This high mortality rate from criminal abortion is traceable to the fact that abortions are done secretively by outcasts of the medical profession and ignorant midwives without antisepsis or asepsis.

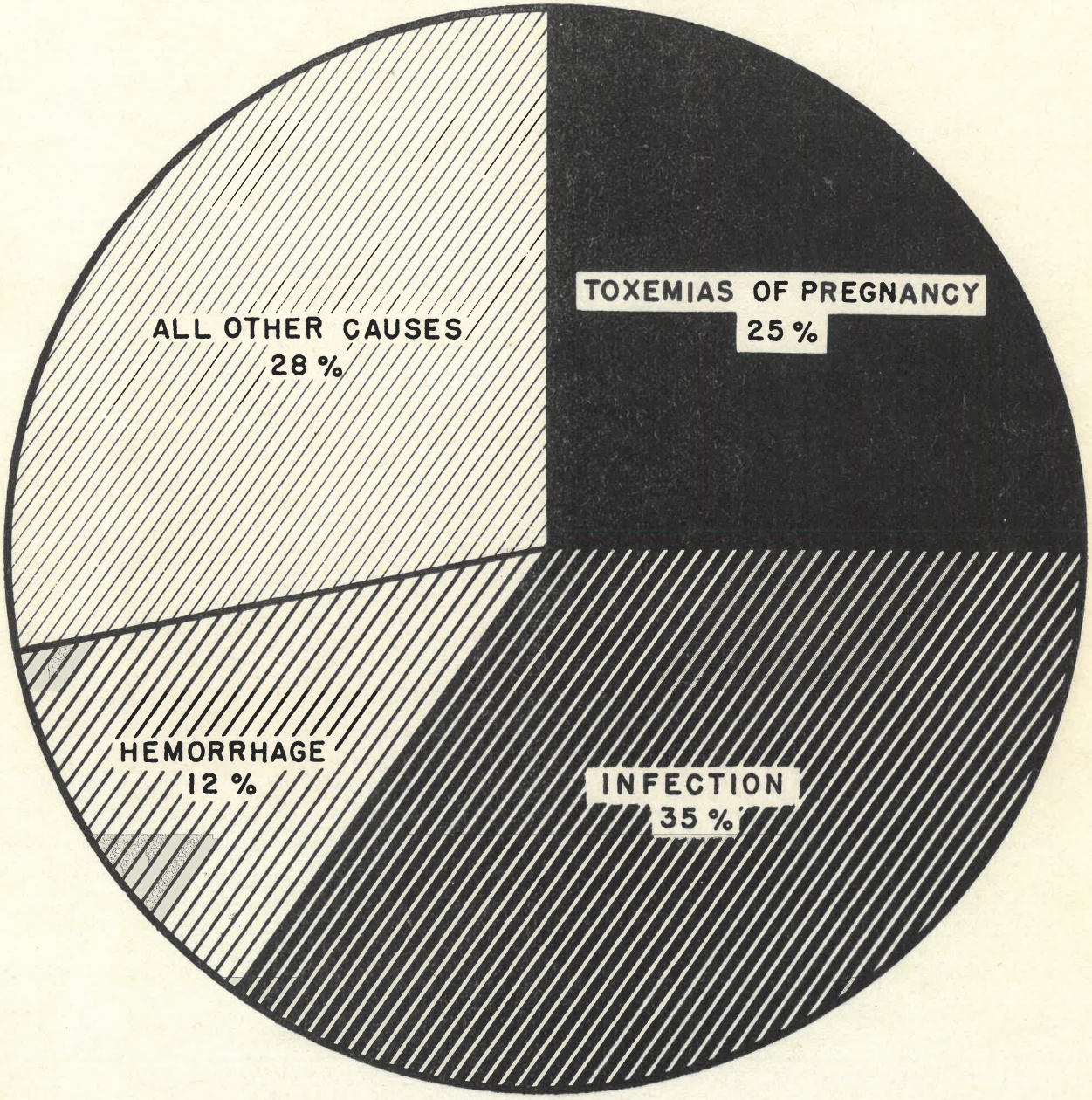
So often aften delivery the mother is forgotten. Postpartum infection is responsible for nearly one third of maternal deaths. This may be due to infection setting in where trauma has been done. Pueperal infection has been tremendously reduced during the past fifty years by adequate postnatal care.

The trend of maternal mortality rates is decidedly downward--26 points in the last ten years. Many factors have contributed to produce these downward trends. The direct cause is the simple fact that more mothers and babies have good care. "The task now is to keep the trend going down and to increase the annual drop until the irreducible minimum is reached when no mother or baby is lost or injured in this country for lack of good care. Probably the irreducible minimum won't be reached until maternal care is provided as is education--free and without stigma for all to use who will, while private care, like private schools, is still available for those who prefer and can pay for it."[4]

Summarizing the causes of maternal mortality:

- Unavoidable causes:
  - Physical deviations
  - Pathological process
  - Abnormal physical development
- Avoidable causes:
  - Society:
    - Social position
    - Environment
    - Character of population
    - Overcrowding
    - City dwellers--factory workers
    - Undernourishment
  - Patient:
    - Failure to take advantage of facilities
    - Indifference
    - Ignorance
    - Personal condition
    - Fad of weight reduction
  - Medical:
    - Inadequate preparation of attendance
    - Hospital technique
    - Caesarean section
    - Lack of judgment
    - Lack of skill
    - Carelessness
    - Incompetence
    - Proprietary hospitals

CAUSES OF MATERNAL MORTALITY
UNITED STATES, 1937



CHILDREN'S BUREAU
U. S. DEPARTMENT OF LABOR

SOURCE: REPORTS OF U. S. BUREAU OF THE CENSUS

(7897)

From the above reports it appears that little or no advance has been made in preventing maternity deaths. Our maternity mortality is much higher than we feel need be, but it has been reduced in the last fifteen years.

The United States Bureau of the Census has issued statistics on maternal and infant mortality for 1938. The maternity mortality rate for the year was 43.5 per 10,000 live births. The infant mortality rate was 51.0 per 10,000 live births. These are the lowest maternity mortality rates on record.

The maternal mortality rate for 1938 was 11 percent lower than that for 1937, 23 percent lower than that for 1936, and 25 percent lower than that of 1934, the year prior to the passage of the Social Security Act by Congress. The infant mortality rate for 1938 was 6 percent lower than that of 1937, 11 percent lower than that of 1936, and 15 percent lower than that of 1936, and 15 percent lower than that of 1934. These remarkable reductions have been attained in a period in which every state, in cooperation with the Federal Government has been actively working for improvement in maternal and child-health conditions.

In the earlier period, 1915-34, maternal mortality rates had decreased little. The maternal mortality rates in 1933 and 1934 were 62 and 59 respectively, as compared with 61 and 62 in 1915 and 1916. Infant mortality, in sharp contrast, had been materially reduced; in 1933 and 1934 the rates were 58 and 60, as compared with 100 and 101 in 1915 and 1916.

Of the 9,953 maternal deaths that occurred in 1938, 3,333 were due to infection, 2,521 to toxemias of pregnancy, 1,320 to hemorrhage, and 2,779 to all other causes. The mortality rate from each of these important causes decreased sharply in 1938.[5]

[1] "Public Health Nursing in Obstetrics", (1st ed.) New York: Maternity Center Association, 1946, page 30

[2] Gladstone, Iago, Maternal Deaths-The Ways to Prevention, New York: Commonwealth Fund, 1937, page 54

[3] Gladstone, Iago, Maternal Deaths-The Ways to Prevention, New York: Commonwealth Fund, 1937, page 56

[4] "Public Health Nursing in Obstetrics", (1st ed.) New York: Maternity Center Association, 1940, page 32

[5] "The Child-Monthly News Summary", Vol. 4 No. 8 Feb. 1940 Children's Bureau, U. S. Dept. of Labor, Wash. D.C.

age is only for mortality, so it would take no stretch of the imagination to realize the great morbidity rate.

There are many pro's and con's about the practice of contraception. There are three types of indication for the use of contraceptives; namely, personal indications, economic indications and medical indications. I will only discuss the first two reasons from the standpoint of criminal abortions and the danger of such to the mother and not from an ethical, moral, or legal standpoint. The later (medical) will be given as classified by Dr. Harry H. Jenkins:

Medical Indications for Contraception:

For protection of life of mother:

- Cardiac disease, classes II, III, IV
- Renal disease
- Hypertension
- Diabetes
- Hyperthyroidism
- Tuberculosis
- Toxemias of organic origin
- Recent or debilitating major surgery
- Recent or debilitating trauma
- Severe anaemia
- Repeated Caesarean section
- Chronic disease of debilitating nature

For protection of health of mother:

- Cardiac disease, classes I, II
- Phychosis and neurosis

Extensive pelvic repair

Uterine inflammations

Uterine prolapse

Uterine anomalies

Vaginal anomalies

Major complications of previous pregnancy

Pregnancy within eighteen months

Contracted pelvis

Pelvic deformities

Malnutrition

Renal infections

Repeated abortions

For protection against the production of abnormal offspring:

Debilitating diseases of mother or father

Repeated defect in previous offspring

Familial psychosis or neurosis

Familial epilepsy

Familial syphilis

Familial alcoholism or narcotism

Economic status of famity

Pregnancy within eighteen months

The Philadelphia Committee states in its report:

"Septic abortion was responsible for over one fifth of all the maternal deaths reviewed. One hundred and two of these 162 deaths followed illegal induction. The laity has not been educated sufficiently to realize the dire consequences of illegally induced abortion. Nor is the seriousness of criminal act recognized. This is shown by the fact that, during the three years of the survey, no conviction was obtained for this crime in Philadelphia. If this group of 102 cases could have been eliminated, the deaths would

have been reduced 14 percent. The death rate from sepsis was far greater in the cases under 28 weeks pregnancy than in those over 28 weeks.

Of the 162 deaths following septic abortion, 114 were in married women, and 48 were in illegitimate pregnancies. This ratio of almost three to one indicates clearly that the cause of self-induced or criminal abortion is not, as has been commonly believed, the result of illegitimate pregnancies, but, in far greater measure, is a direct corollary of economic and social conditions."

Dr. Fredrick J. Taussig speaks of abortion as probably the most wasteful of known ills in its expenditure of human life and human health. "He suggests:

1. Intensive study of the underlying causes of spontaneous abortion and its prevention.
2. Better training of physicians in the prevention and treatment of abortion.
3. Better hospital facilities for abortion patients.
4. Improvement in home and working conditions for the pregnant mother.
5. Broader and more humane indications for medical interruption of pregnancy.
6. A change in our laws permitting medical intervention in place of the prevalent resort to personal manipulations, or to induction by a professional abortionist or midwife.
7. Education of women concerning the dangers of abortions.
8. Improved economic and housing conditions among the poor, to decrease the necessity for resorting to abortion.
9. Sterilization of those who for medical reasons should not have more children, or any children at all.
10. Widespread establishment of maternal health clinics under medical control to teach women safe and harmless methods of contraception.

From the above statements, it is well understood that abortions are a problem in maternity care. Now the question arises whether or not contraception should be legalized. Dr. Harry Jenkins states: As a vital factor in the prevention of death and debility among our women and children, contraception must be ranked just below, if not equal to adequate prenatal care.

STANDARDS OF MATERNITY CARE

Chapter VI

"The aim of adequate maternity care is to secure for every pregnant mother the minimum of physical discomfort throughout pregnancy, the maximum of physical fitness at its termination with a well baby and the knowledge whereby to care for her baby."[1]

The standards for maternity care has certainly taken a long slow advance as has been shown by history. Literature reveals no complete exposition of the fundamental principles of maternal welfare until William Buchan published in 1803 "Advice to Mothers". He presented most of the basic ideas which are accepted today as the essentials of maternity welfare. He writes--"The want of proper instruction at an early age betrays mothers into a variety of fatal mistakes respecting their own health as well as that of their children". He further states, "I do not know any manner in which humanity, charity, and patriotism can be more laudably exerted, or even a part of the public revenue more usefully employed than in enabling mothers to bring up a healthy and hardy race of men, fit to earn their livelihood by useful employments and to defend their country in the hour of danger."

At the beginning of this century Pinard stresses the importance of the obstetric examination of pregnant women, and certain institutions were established in France for their care. At this period Ballabtyne was establishing prematernity wards for the antepartum care of women with complications, and he prophesied in an imaginary conversation that by 1840 the obstetricians would wonder why those of a generation before had spent so much time and thought about the few hours of labor and so little concerning the nine

months of pregnancy. This has been realized in our country and even further advances have been made, as complete maternal care is now recognized not only as desirable but as essential for the future welfare of our nation.

Standards of maternity care as published by the Committee on Maternity Care of the Children's Welfare Federation includes: (1) Prenatal care--clinical visits and home visits (2) Delivery service--hospital and home (3) Post natal--mother and baby (4) Qualifications and responsibility of personnel--medical, nursing, social.

Prenatal care is the supervision, care, and instruction given to pregnant women. This care should include: 1. a visit to a physician or clinic as early in pregnancy as possible at which time a complete history and physical should be done, 2. regular visits to the physician or clinic at least once a month during the first seven months, and then every two weeks after that, or oftener as indicated, 3. group teaching in prenatal clinic which will instruct the mother in care of herself, the preparation for delivery and the care of the baby upon its arrival, 4. arrangements for referring of clinic patients, 5. arrangements for referring of clinic patients to other institutions equipped to give the desired care which for any reason cannot be given by the institution or organization first approached, 6. a carefully integrated medical social plan for clinic patients, by developing a contact between the clinic and the patient which will help to solve any social or economic problems which may effect the health

and peace of mind of the patient or prevent her following instructions, 7. home visits by a supervised public health nurse in accordance with the physician's instructions, are desirable both for institutional and private practitioner's patients.

The delivery itself should be done under as aseptic conditions as possible. Adequate medical and nursing care should be given whether at home or hospital delivery. An attempt should be made to maintain the same standards in home deliveries as are maintained in hospital deliveries. Care of the patients after delivery should include careful inspection and supervision and every effort to guard against complications. Only the properly trained and responsible obstetrical staff should be included in the maternity care. Sufficient personnel should be available to do the social service and follow-up not covered by the nursing personnel.

[1]Zabriskie, B. Nursing Handbook of Obstetrics: page 451

DEVELOPMENT OF PUBLIC HEALTH IN MATERNITY CARE

Chapter VII

There are excellent facilities for obstetrical care in this country and many women enjoy their advantages yearly. Ideal care has been given by many American obstetricians. The American Board of Obstetrics and Gynecology recognize about 1,000 obstetricians as competent specialists. In addition there are many other physicians who are qualified to do safe obstetrics. There are more than 2,700 hospitals approved by the American College of Surgeons. There are 23,000 public health nurses who carry out many maternity programs. There are many well prepared dentists. Social workers aid the family in problems that disturb the mother's peace of mind. Several states have laws requiring premarital examinations. There is a consciousness of the need of preparation for marriage. But with all these facilities, no community in the United States has given adequate maternal care. The good care is not equally divided throughout the country. Obviously, too few American women are receiving the minimum care that makes child-bearing a reasonably safe adventure.

"There are more than 1,300 counties without a hospital, 1,000 without a public health nurse. There are many proprietary maternity hospitals of questionable character and many others which do not meet the minimum requirements for approval by the American College of Surgeons."[1] Almost every day there are approximately 2,000,000 pregnant women

in the United States. Less than half of these mothers received adequate care.

To provide adequate maternity care for the mothers of this country is a tremendous problem, no program for which has yet developed. The machanical handicaps alone are difficult to meet. There are 3,026,789 square miles of territory in the United States which includes many inaccessable homes. The Health Service is very inadequate in many communities. There are wide stretches of country where there are no doctors or public health nurses. These pregnant women are of all races, many of them living in a climate and under conditions that are new and strange to them, and thousands of these pregnant women are forced to depend upon untrained mid-wives, their husbands or neighbors for care when babies are born. Intermarriage between variant physiques results in obstetrical difficulties. Our large Negro population admittedly does not get proper care. Operative interference has been popular and thereby too prevalent. The demand for comfort on the part of the patient, coupled with the physician's inexperience, leads to the abuse of pain-relieving drugs. The widespread practice of criminal abortion is an obvious hazard. We are attacking this unique maternal problem by the following measures: more scientific obstetrics, the availability of care by governmental and private organizations to the needy, the condemning of harmful drugs, and the education of the public in regard to abortion.

The maternal need must have a fourfold approach: educational, economic, social, and professional. From the educational standpoint, there is a widespread ignorance of the need of skilled obstetrical care. From the economic standpoint there is a financial inability for the average woman to afford proper maternity care. From the social atandpoint, the general public has failed to recognize the situation as one of national importance. From the professional standpoint there is an inadequacy of available obstetrical service.

In many large cities where the best maternity care is available to both those who can pay and those who can not, women fail to take advantage of the opportunities. As has been stated previously this may be due to ignorance of such facilities or failure to cooperate. It is the rural women who are generally unprovided for.

Several foreign countries are far advanced and have evinced more concern for maternal welfare than that of the United States. The actual origin of prenatal care is difficult to locate. Dr. Ballantyne, of Edinburgh, is generally regarded as the father of the prenatal work because of his work on abnormalities of pregnancy and his insistence upon the importance of what might be accomplished through intelligent care and supervision of all women, not alone abnormal cases, throughout pregnancy. In England maternity care has been for nearly twenty years under the supervision and instruction of midwives who are trained, registered and con-

trolled by government authority. They have a very low maternity and infant mortality rate. This is accomplished through "a maternity benefit which helps the mother to pay for obstetrical care, and partly through indirect government aid, in the form of compulsory notification of births. A great increase in the number of "health visitors" and welfare centers, and government grants to local authorities which defrayed half of the expense of giving prenatal, natal and postnatal care and of instructing mothers in the care of themselves and their babies. Special effort has been made to help the mothers in rural sections; more small hospitals being maintained, more physicians being provided and assistance given in caring for older children, during the mother's absence, if she was obliged to go to a hospital at time of delivery."[2]

The beginning of important events in the development of maternal care in the United States started under the leadership of Mrs. Putnam. This was in Boston in 1909 under the auspices of the Women's Municipal League. The work, was designed to show what could be accomplished by intensive work in a small group of city mothers, and suggest feasibility of its extension to larger numbers. From this committee, formed twenty years ago, has come national, state and local leadership in developing programs to conserve health and lives of the mother, the fetus, and the newborn.

Today many national, state, and local programs have been instigated. The White House Conference on Child Health Protection in 1930 appointed a committee on prenatal and maternal care. This committee made a thorough investigation of maternity problems and methods of solution.

Many maternity centers have been established in large cities to aid the mothers unable to pay for their adequate maternal care. Clinics have been established by hospitals,

public health nurses, and volunteer organizations.

The end really to be desired through maternity care is not so much the mere promotion of health, but our future generation must be saved to mental and physical health, vigor and well-being, capable of being useful productive citizens.

[1] Public Health Nursing in Obstetrics, (1st ed.) New York: Maternity Center Association, 1940 page 3

LEGISLATION

Chapter VII

The growing consciousness of a need for adequate maternity care has been evidenced by legislation both national and state. The most comprehensive program had its beginnings in the Sheppard-Towner Act which was attacked and finally failed to receive federal appropriations. Similar and even more far-reaching legislation has been incorporated in Section V of the Social Security Act which has stimulated and put into effect educational service, and research activities in the fields of maternal and infant health in various states and territories. As to maternal and child-health services and services for crippled children, the act requires that the plans submitted by the state agencies shall include provision for cooperation with medical, nursing, health, and welfare groups and organizations. State plans submitted for maternal and child-health services must show that their operation will assist in the extension and improvement of local maternal and child-health services. The annual appropriation authorized for grants to states for maternal and child-health services, $5,820,000 is for the purpose of inabling each state to extend and improve, as far as is practicable under the conditions in such state services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress. State funds

appropriated or otherwise provided by the state itself must be made available for payment of part of the costs of approved plans. Funds appropriated or made available by counties, cities, towns, or other political subdivisions of a state may also be counted as part of the total funds made available for maternal and child-health activities, provided such local activities are brought into the state plan and are under the general supervision of the state department of health. State or local funds used for matching on allotment under eligibility for federal assistance under this portion of the Social Security Act, public funds expended for maternal and child-health services may be counted in the matching funds available by the state if they are used for public expenditure.

Many of the states have passed prenatal and marriage laws. Much has been done to insure protection and health to the mother and baby by such legislation. As the public becomes more aware of the safeguard by such legislation it will come into effect as a national program.

Marriage laws should be enacted that no application for marriage license shall be accepted unless accompanied by a statement signed by a duly licensed physician stating that the applicants have been given an examination including a serological test for the discovery of syphilis and a test for gonohrrea. This law would act as a preventive measure and would carry more punch than fifty years of continued treatment for malformed and leuetic babies and puritic parents.

"A stitch in time saves nine." In these cases it works a hundred percent.

It seems most likely that the congenital syphilitic, in every instance, contacts the disease from the mother. If the mother has syphilis, early or late, the fetus will usually get the disease. The sure cure for congenital syphilis is to prevent it. This can be done if the disease in the pregnant woman is recognized, and the earlier in pregnancy the better the chance for the unborn child. When Utopia is reached, every prospective mother will have a haven of perfect care.

Every physician attending pregnant women should take a sample blood for serology tests. If the mother has a positive serology, immediate treatment can be started. Preventive medicine must be carried out in the maternity program for effective results.

PLACE OF OBSTETRICS IN PUBLIC HEALTH NURSING

Chapter VIII

A concentrated effort is being made over the world to improve the practice of obstetrics. It seems a tragedy that this specialty above all others, should be so closely interwoven in the economic affairs of the people. There can be no short-cut in good obstetrics. To obtain the best results for mother and baby the way is long and laborious. Best results, as a rule, in our country cost money, and childbirth is not a monopoly of the well-to-do. The nurse of the future is going to play a very large part in the solving of the obstetrical problem, particularly along prenatal and preventive lines.

Every nurse should recognize it as her duty to advise an unsupervised pregnant woman to place herself under medical care, no matter under what conditions she might find her. In the discharge of her duties the nurse will sometimes need no little ingenuity to adapt herself to the routines of prenatal care as prescribes by her organization, to the mentality, traditions, and varied demand of the daily lives of her patients. But this will have to be done, for, though in a general way, the needs of all expectant mothers are the same, their circumstances and personalities are infinitely varied.

It may require tact and resourcefulness to convince a patient that details of care which seem wholly unrelated to her or her baby's welfare will actually increase their chances for life and health. For this reason, it is almost of prime importance that the nurse win her patient's friendship and confidence. It is not the single details that count, but an aggregate and repetition of the infinite number of details that make up the expectant mother's mental and physical life.

In addition to a definite relation to the expectant mother, nurses are meeting them unofficially and informally. Women who are needing, but not receiving care from a doctor or organization; women puzzled over their condition; women who do not know how to obtain advice, and women who do not cooperate with their medical assistance.

It is the business of the nurse to be a good salesman--to find her customer and sell her product. A great deal is expected of the public health nurse who undertakes maternity and infant hygiene work. She is expected to find mothers early in pregnancy and get them under medical supervision. As a rule, neither the pregnant mothers nor their families recognize any need for care much before the baby is expected. The nurse's first job therefore is to teach the mothers and families why any care is necessary during the prenatal period and what this care is. The mother must be convinced of the value of this care to her baby and herself before she is willing to spend her time and money get it. No nurse

can attempt anything so difficult unless she herself knows obstetrics and its many problems; and, because of her knowledge, believes in the necessity for care; believes that she can teach the things she knows; and is truly interested in each mother and her problem. The nurse is a publicity agent for maternity care.

Obstetricians require cooperation. It is at this point that the nurses are more and more needed. A private patient who is in the care of an obstetrician is of course supervised and instructed by the doctor. But there are patients who can not afford individual care, but who need care none the less. It is this patient that the nurse can help by teaching maternal hygiene through visiting nurse societies, out-patient departments of hospitals and through pre-natal clinics.

As has been stated before, the midwife will probably play an important role in maternity care for some time in our isolated districts, but she can not fulfill this role unless she has proper instruction. The public health nurse especially if she becomes a nurse midwife will be of great value in instructing and aiding the midwives and setting up an adequate organized system of meeting maternity problems in rural districts. It will be in her capacity to make the midwife understand the importance of early prenatal care and necessity of immediate skilled and scientific aid in cases of complications. In this field the public health nurse will have many problems to face--not all directly maternity problems, but of such a bearing that she will have to meet them

with tact and an understanding of human character.

The public health nurse has not finished a job to satisfaction by teaching the mother, aiding the doctor, or instructing the midwife, but only when she has taught the community the importance of good maternity care. She must show them the need and economics of a well-rounded program. Then she must help them organize their own program for a happier, healthier community. By showing the community their responsibility and having them work out their problems, maternity care will be on the upward stride.

WHAT CAN BE DONE

Chapter IX

President Hoover in a White House Conference address said, "If we could have but one generation of properly born, trained, educated and healthy children, a thousand other problems of the government would vanish. We would assure ourselves of healthier minds in more vigorous bodies to direct the energies of our nation, to get greater heights of achievement, moreover, one good community nurse will save a dozen future policemen."

Maternity care will be improved only if a concentrated effort in which all who share responsibility will contribute their respective efforts. This requires individual, group, and community organization. They must realize that the world's progress depends upon the highest and most important function of woman kind.

The movement for the improvement of maternal health and for full prenatal care takes in a wide range of activity. It covers the field of continued advice to the pregnant women by instruction given by her physician, information made available by official bodies and medical groups, by books and pamphlets, and by all the more elaborate devices of the methods of lightenment--radio, film, lectures, and other avenues for disseminating information. The extension of preventure medicine in pregnancy has also lead to special training of midwives, has altered the instruction given to the medical student, has brought about the establishment of maternal health centers. has stimulated the founding of visiting nurses!

settlements, and has evoked special concern for maternity hospitals and dispensaries as well as concentrated efforts to aid on the part of the social worker.

The medical profession alone will not be able to remedy the present maternity situation, but it should set the standard and show the methods of solution. It is the physician and nurse who must be the leaders. However, the medical profession must be well equiped and qualified to be such a leader.

The undergraduate medical student must be made to realize that his curriculum is not adequate to qualify him as a specialist in obstetrics. "Well-defined standards for preliminary study and training to be undergone by the physician before he may claim to be a specialist, the creation of adequate facilities for giving the required postgraduate study and training, the certification of such specialists of major operative procedures to only such qualified specialists are some of the "Steps of Progress" self-medicated and self-imposed by the medical profession."[1]

Much can be said on proper instruction facilities and interest to make the best obstetrician, but to summarize briefly, an undergraduate course in obstetrics to be satisfactory should have ample facilities, a reasonable allotment of time, capable teachers, and maintenance of high standards by the institution as a whole.

The obstetrician is very apt to serve to his individual patients. He does not look at his service from a community point of view although helping the individual does help the group. Very few practice preventive medicine. If such a viewpoint could be inculcated in all medical students and practitioners, a community program would soon be set up on prevention of maternity mortality and morbidity.

Closely related to the physician is the nurse. She must have adequate training for her responsibility can not be fulfilled by the doctor or the midwife. She is an important wheel in the machinery.

Hospital schools of nursing care are tending to teach obstetrical nursing on the basis of what the student sees during the two weeks the patient is in the hospital. There could be no greater falicy. The patient is a maternity patient in that she requires health supervision for something like ten months instead of only two weeks. The events of the first nine months are often responsible for the difficulties the patient suffers and the student sees during the two weeks of hospitalization. All too often the nurse when she begins practicing does not remember what she has been taught about prenatal care because she has had no practical experience and the hospital experience was not associated with reality. The observations of and lessons on the lying-in period do not constitute a real course in maternity nursing. It is up to the nurse to persuade the young mother and likewise the yound father of the importance of early medical supervision. She must teach hygiene of pregnancy and secure the confidence and allay the anxiety of the anxious or ignorant young mother. We need better teaching of obstetrics in our schools of nursing to arouse conscientiousness on the part of nurses.

Obstetrical training for nurses should be regarded as fundamental in the teaching curriculum and it is essential therefore that further cooperation take place between the

medical and nursing groups to attain this end. The White House Committee on Child Health, Committee on Nursing Education, demonstrated the lack of knowledge on the part of the nurses as a class of what adequate maternity care means. A questionnaire directed to the various nursing groups showed a lack of knowledge in obstetrical nursing. The place of obstetrical training in the hospital curriculum is evidently in need of revision and steps must be taken to reform a system in which the students time in the hospital is usually arranged to meet the needs of the institution for nursing care rather than to secure every student a balanced and complete experience in nursing, there is a need of competent nurse instructors.

The field of obstetrical nursing has been greatly extended and modified in recent years, especially along the lines of public health activities. In order for certain of these functions to be properly fulfilled it may become necessary to train nurses as midwives. The value of nurses as midwives has been satisfactorily demonstrated by the Frontier Nursing Service.

Improved nursing care must be provided in any scheme to improve the puerperal mortality situation in this country. The nurse must develop an obstetrical conscience just as this is necessary in the doctor and therefore the two professions must work hand in hand, educated along more practical and humanitarian lines. Nurses are not embryo doctors.

The nursing program in maternity is directly dependent upon the nurse's knowledge of the subject and her method of presentation. The degree of success rests on the amount of cooperation between medical and the nursing profession. The nurse's ability to meet the needs of the individual patient is responsible, in no small degree for the development of the maternity program. She must know maternity work in all its aspects. Good maternity nursing involves accurate scientific knowledge, adaptability to the needs of the individual patient and utilization of teaching opportunities.

An important thing to be considered in maternity care is that not enough people know what it is about in all its elements or are not putting into practice what they do know. This is true of nurses as well as doctors and laymen. This field demands a combination of knowledge, skill, and common sense. Some nurses have precise technique; some less knowledge of the process of pregnancy, but with more elastic understanding of the patient and her environment. All two few have a combination of both. It is the well-rounded person who knows how to correlate her information who makes the best maternity nurse.

The nurse must know her field well and be a good teacher. The public health nurse enters thousands of homes. It is her function to teach the pregnant woman the fundamentals of maternity hygiene, antipartum and postpartum care. She must urge medical care, teach basic facts of nutrition, and prevention of infection, and not least of all she must under-

stand human nature--be a psychologist, a leader of people, and highly interested in the betterment of her community.

It must be remembered that 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, 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, and provisions must be made for them to receive such training.

The United States has 47,000 midwives and other women who are called upon to attend fifteen per cent of births.[2] Only a few of them are trained. Most of these women are in the South. They are usually ignorant, dirty, and superstitious.

The communities give the following reasons for need of midwives (1) racial customs (2) economic conditions (3) sparseness of population (4) scarcity of physicians.

As for the numberless thousands of mothers who have no choice in the matter--our small town and country poorer classes who cannot afford the services of a physician and to whom no free clinic is available, the hope is for more rigid regulation regarding the training of midwives and for a more thorough-going public health program. To ignore and supress the activities of these attendants is futile. As long as there are babies born there will be midwives. They is a necessity in many communities, but there should be an adequate

system of training, supervision, and registration.

In some states, midwives are licensed and their practice is carefully supervised; in others, midwives--though licensed--are given no supervision; and in others midwives are not licensed or supervised. If midwives are to continue in the maternity program, new methods of instruction and and licensing must be adopted.

One method of solving the problem quite adequately has been worked out by the Frontier Nursing Service of Kentucky. Here, nurse-obstetrical assistants work under the supervision of competent obstetricians. Graduate nurses receive special training in obstetrics. They assist in routine care of pregnant women during the antepartum period, and in uncomplicated cases attend the delivery. Because of the relief they afford the obstetrician from routine obligations, he is free to concentrate his services on those patients requiring expert skill. In this manner the benefits of competent supervision can be extended to a larger number of pregnant women, the costs of services will be proportionately reduced, and, in time, the midwife evil will be eliminated.

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 the 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 facilities at the service of the physician rate second only to the importance of the skill and competence of the physician. Hospital facilities must therefore be brought up to at least the minimum standard of safety and efficiency. There must be well-equiped, separate obstetric departments in hospitals admitting maternity patients, adequate nursery facilities, and a means of isolation of any infected patient. It should be the responsibility of the medical staff that the hospital meet these standards, and the public should know which hospitals qualify and the advantage of accepting delivery only those which meet the necessary standards.

There is somewhat of a problem in the so-called "maternity homes" especially in regard to equipment and whether or not registered nurses are in charge. The solution of this problem seems to be in the direction of licensure and supervision by the governmental authorities with the cooperation of obstetrical pluperious.

The community has a definite obligation to the maternity program. The future of the community depends on the health of the mother. The cooperation of the community will be gained only by education of the public to the need. Any program for maternal welfare which aims to integrate and to utilize to the full all available resources calls for clear

plans, the assignment of responsibility, and the exercise of vigilant supervision. Unless the schemes are clearly formulated in detail and a special body of interested persons is devoted to their accomplishment, little will be done. Hence once interest has been aroused in the maternal hygiene problem, each community should have, associated possibly with the official health organization, a commission or body of an advisory nature to aid it in dealing with the problems of maternal mortality and infant welfare. In such a commission may be included representatives of the official medical societies and specialty groups; obstetrical, gynecological, surgical; representatives of the various hospital groups, official, voluntary, proprietory, denominational; representatives of voluntary health organizations, notably the maternity organizations, the antituberculoses and heart disease societies, and the Red Cross; representatives of the private and public health nursing societies; representatives of the service clubs and of women's organizations.[3]

The public health department should act as a guide to the community and an interpreter for the obstetrician in the problems of maternity welfare.

The pregnant woman herself must be early educated in maternal hygiene. Many methods have been used and have proved very satisfactory. Prenatal and postnatal clinics, mothers' classes, prenatal letters, mothers' correspondence courses, maternal welfare pamphlets and books, moving pictures, exhibits, talks, radio, consultation clinics, and dental clinics are

MORE ABUNDANT LIFE

Chapter X

Obstetrical care has expanded through the years. It has advanced to a stage where it is not just a matter of caring for the mother, but attention is now given to all the physiological processes and psychologic reactions of the mother during the whole maternal cycle. It embodies the entire family and in a broad sense the progress of the nation.

Family life plays an important part in the maternity program. As has been states before, each mother and baby should have that state of mental, emotional, and plupical health which is their optinium. Happiness must be secured in the home. Anxiety and worry are a menace to the mother. Divorces, unhappy homes, and the number of abortions show how often happiness is not attained.

Obstetrical care must reach out and include instruction, counsel and health promotion. Divorces and abortions must be fewer--the lives of men and women made fuller, richer. Homes must be created by love.

The maternity program must be made to include men and women who have a knowledge of people and a willingness to help them. We must set up a program of prophylaxis.

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