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NATIONAL CATHOLIC HOSPITAL AND HOME SERVICE FOR THE IMPROVEMENT OF MATERNAL AND INFANT CARE

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Prior to the seventeenth century, the care of women during childbirth was entirely in the control of midwives, who, while usually to some extent experienced, were never professionally trained. Physicians in those days never directly assisted women during childbirth, but their writings show evidence of their interest in the subject and of their realization of the dangers and risks which women incur during pregnancy and parturition. In the hope of diminishing the numerous fatalities, they prescribed rules and instructions for the guidance of the midwife in normal as well as obstructed labors. They also urged the selection of experienced rather than inexperienced, or occasional, midwives for the care of normal as well as complicated labor.

The development of modern obstetrics began during the seventeenth century when physicians were first allowed to attend women during childbirth. Once having gained the opportunity of acquiring experience in the care of women during actual labor, the physicians laid down the principles for proper care based on a sound knowledge of anatomy and physiology, and these principles developed rapidly into the science of obstetrics.

Modern obstetrics was devel-

oped during this period by a few great teachers, the first specialists in this branch of medicine and surgery. After its acceptance by the medical profession, the subject was taught in the medical schools throughout Europe. The mortality rate declined with the improved training and control of the midwife. At the present time, the mortality rate is lowest in those countries where the delivery of normal cases is almost entirely in the hands of the midwife. In England, where the midwives have charge of only 50 per cent of the deliveries, the mortality rate is higher than in the countries on the Continent where midwives deliver 85 to 90 per cent, but lower than in the United States where the practice is in control of physicians, with untrained midwives caring for about 20 per cent of the cases.

From the very beginning maternity hospitals were established in connection with the medical centers of Europe for the twofold purpose of providing special obstetrical care for women in need, and of training medical students and midwives in practical obstetrics. It was understood that the midwife could be trained to deliver a normal case with an adequate degree of safety, and could be depended upon in most cases to rec-

ognize the early appearance of any unusual condition which might require hospitalization or the attention of a physician in the home. As a result, during the eighteenth century great progress was made in reducing the loss of life during childbirth. The maternity hospitals established in connection with the European medical schools were, and have continued to be, the great training schools for midwives as well as for the specialist in obstetrics.

It required the active and sincere cooperation of the Government with the medical profession to enable the control and training of the midwife and physician to be accomplished. The duties of the midwife during childbirth as well as her limitations were clearly defined and enforced by law. Because the State with the cooperation of the medical profession has continued to respect and protect the rights of the trained midwife in European countries, only a limited number of physicians intending to teach or practice as specialists require training in the medical schools and hospitals. In most of the European countries the demand for the services of the midwife is still common among all classes. The services of the obstetrician, except among wealthy women in larger cities, are considered unnecessary unless complications, or difficult labor, demand expert attention. Yet, the mortality in these countries is only about half what it is in the United States

—3.16 per 1,000 live births in Holland (1933) as compared with 5.9 per 1,000 live births here (1934).

The thorough training given in the European maternity hospitals and special schools under government control has enabled the midwife to adapt herself to the new advances made by the medical profession. The standing and control of the midwife throughout Europe in general has been greatly enhanced by the unusually high standard of training and the remarkable results attained by the midwife in the Netherlands and Scandinavia. Many of the schools in the latter countries have been well organized and active in training students for over one hundred years. The number of midwives trained is strictly limited by the State to public needs. On completion of their training the midwives are assured without delay not only of economic security but also of a position of standing and responsibility in the community. Therefore, the authorities have little difficulty in securing the best type of candidates for this training.

As a result of the careful selection and training of the midwife, as well as the availability of trained medical assistance at all times, the mortality rate for mothers and babies in these Northern countries has fallen to a point unparalleled elsewhere.

That comparable results could be obtained in other countries by trained medical assistants has

been shown by isolated experiments—for example, by the East End Hospital in London where in 20,060 deliveries, excluding abortions, the mortality rate of 0.7 per 1,000 equaled the best showing even in Holland. For many years this institution, organized for the care of patients in their homes by properly supervised obstetrical nurses, has shown unusually low mortality rates in its reports. These patients, as is customary on the Continent, have adequate medical supervision during pregnancy, and only those patients selected as normal are delivered in their homes. The nurses engaged in the care and delivery of these normal patients are trained to call promptly for medical assistance should complications develop during or following labor. An experienced physician, if needed, is always available in the neighborhood to assist these nurses. When serious complications, or difficult labors are encountered, the patient is hospitalized and has the attention of a skilled obstetrician.

Prenatal care for large groups of patients should be under the supervision of an experienced obstetrician if we are to assure prevention and proper care of complications and make certain of normal and safe delivery at the end of pregnancy. Expert observation during the latter part of pregnancy definitely determines those cases which are to expect normal parturition and at the

same time assures special attention for abnormal cases needing obstetrical judgment and skill for their protection. With adequate prenatal care, over 90 per cent should have natural termination of labor.

In this country no attempt has ever been made to train groups of similarly equipped midwives or nurses for the care of normal cases to act as independent midwives or as assistants to physicians. I believe the failure to appreciate the value of the thoroughly trained obstetrical nurse must be regarded as an essential cause of the generally poor results obtained in this country. This failure has also been a factor in the recent trend to hospitals for care during confinement. This movement, because of its rapid development, has forced hospitals in meeting the demand to accept in many instances more patients than they were properly organized or equipped to care for. Experience has shown that the physician with a nurse properly trained is able to protect his patient in normal cases in the home with less risk than in a hospital that is overcrowded or not properly organized and equipped for maternity care. I feel that, when adequate protection can be assured in the home during confinement, home care is preferable to hospitalization in normal cases, in that it affords greater protection against infection and unnecessary operative interference.

Moreover, the training of physicians in obstetrics has been woefully inadequate. The medical profession in America and in England has always assumed that, because obstetrics is recognized as a science and a branch of medicine and surgery, the practice should be entirely in their hands. Our medical schools have always attempted, and still attempt today, to teach practical obstetrics to all graduates. As a result, because of the number to be taught and the lack of clinical facilities, the extent of the training received is inadequate for the proper protection of women during pregnancy and childbirth. Despite this fact, which teaching authorities in the profession have always conceded, the civil authorities and the medical profession continue year after year to permit all physicians upon graduation to accept the grave responsibility of providing maternity care, though they are without adequate training in this field.

Long experience in teaching and training graduates in medicine in maternity hospitals has convinced me that it requires many months of strict internship in a well-organized and active maternity service before any graduate is competent to assume responsibility in practice for the care of *even normal cases*. The graduates who in private practice acquire sound judgment and skill in managing *complicated cases* without previous supervised training in a maternity hospital, are negligible.

While instruction in the funda-

mental theory of obstetrics is necessary for all students in the medical school, training in practical obstetrics should be optional, and be provided only for students who intend to practice obstetrics. The number of such students should be limited to the clinical facilities available in each medical school.

I am further convinced that this limitation of practical teaching to a definite number of students in medical schools would quickly force some action by the civil authorities in the direction of insisting that the practice of this branch of medicine should be confined to those physicians who should have first acquired adequate extra training in some well-organized maternity service.

Any broad plan for maternity service must be based on the kind of care which is provided by the experienced obstetrician in his private practice. It is not essential, however, in any plan devised for the care of all classes that every woman must necessarily throughout pregnancy be under the immediate surveillance of an obstetrician, but it is essential that this plan assure to every woman during her prenatal period adequate individual attention under the general direction of such a specialist.

From my experience in the care of maternity patients in various types of hospitals I am convinced that it is possible to develop in this country a number of maternity centers with combined hospital and home services—teach-

ing institutions which would in time be capable of such extension as to ensure adequate protection to all women during pregnancy and childbirth. The best proof of what can be accomplished by such institutions on a national scale is shown by the results in Continental countries. England also is at present preparing to reorganize its schools for midwives as the basis for a similar nationwide system.

The results in three large maternity hospitals—Nursery and Childs, New York Lying-in and Manhattan Maternity Hospital—in New York City during the past half-century are evidence of the definite accomplishment to be expected from the hospital with a home service. These hospitals maintained a high standard of care for many years in New York City, and at the same time—which is equally important, because the problem is not a transient one—developed training schools where physicians obtained a thorough and practical knowledge of the fundamental principles of obstetrics. As in European countries, these hospitals emphasized the normal in pregnancy as well as in labor, while for the management and care of the abnormal they developed in many physicians the essential obstetrical judgment and skill.

There is no doubt that the establishment of these independent teaching institutions was due to the influence of the great contemporary teachers in obstetrics who

had obtained their training abroad, and had thus a clear insight into the importance of such institutions for the immediate and future needs of America. For a great many years they served as the much-needed practical schools for the training of physicians from all parts of this country as well as from Canada, who were forced to seek training, as students or graduates, in these hospitals. There is hardly an outstanding maternity hospital or medical school in the country which has not been influenced for the better by the services of one or more of these graduates. Unfortunately, because of financial difficulties, these three independent teaching institutions with combined home and hospital services have disappeared.

The service performed by these institutions cannot be overestimated, and there is urgent need now to develop some system of training to take their places. Modified to fit the needs of different communities, with special training for nurses, these old institutions might well be used as models for similar maternity centers throughout the country.

I feel that it would be possible to develop a national service of maternity care through the agency of Catholic Sisters, who are now in control of maternity services in all parts of the country. The Association of Catholic Hospitals should seize the present opportunity to provide adequate maternity care for all women,

while simultaneously assisting in the training of future nurses and obstetricians. This movement for better maternity care would open the door wide to innumerable forms of Catholic action for the betterment of family life. Moreover, both now and in the future, we would be rendering a direct service to the country as a whole by the saving of lives, and would be in a better position to furnish Catholic physicians with an opportunity to contribute in many ways to the advancement of the science and art of obstetrics.

The organization of a Catholic Maternity Hospital Association would facilitate the development of a constructive plan. Such an association would direct its member units—each one of which would be organized to assure a high standard of maternity care and at the same time maintain a thorough training in practical obstetrics for nurses and physicians.

I believe that the following fundamental principles are necessary for success in carrying out this plan:

(1) Maternity hospitals should be organized and maintained as teaching institutions, and be combined when possible with a home service.

(2) A thoroughly trained resident obstetrician should be in charge of every maternity service. This position is so essential to the best results in providing adequate care and in the teaching of nurses and graduates that it should be regarded as the keystone to the

organization. Any obstetrician with teaching ability and competent to manage abnormal cases is worthy of sufficient salary to enable him to occupy such a position for several years.

(3) The Sisters or nurses in charge or responsible for the care of patients and the teaching of nurses should have had previously a thorough training in the practical care of normal cases. The nurses in training should be graduates and carefully selected as suitable for this field of work. The services of these nurses would be so valuable to the reduction of maternal mortality in the future that every effort should be made to establish a plan for their future whereby they may be assured economic security. The training of the nurses should be far more thorough than has been heretofore provided in this country. Like that furnished midwives in the European schools which I have mentioned, it should equip them to care not only for patients in the home or hospital as assistants to physicians but in rural districts where the doctor is often not immediately available. This special training, it should be understood, would qualify them, not to replace the physician, but to act as competent assistants in protecting his patient. I believe that in the beginning a number of Sisters and nurses might well be sent for their training to one of the well-organized schools in Northern Europe.

(4) It is essential in providing for adequate maternity care that

the authorities shall not have to depend on the income received from the patients for the financial support of the hospital. Consequently, some financial support outside of that received through patients must be provided. The maternity care should be supplied to every patient without any consideration of the amount the patient is able to pay.

(5) Finally we come to the consideration of a problem, the solution of which may be achieved under the direction of the Catholic Maternity Association.

I do not need to emphasize the fact that the long years of unemployment with the accompanying social and economic disturbances have seriously affected many of the conditions essential for the establishment and well-being of the family. Because of these serious economic problems it is not surprising that the birth control movement is making rapid progress even among Catholics. The publicity, which gives it scientific standing, and the attempt to have it accepted as a recognized therapeutic measure, have also aided in spreading the movement. There is no question that its influence has already involved Catholic mothers who are now misguidedly using contraceptives to protect their health, or to limit the size of their family. The appalling and steady rise in the abortion rates in the very localities where contraception is most widely practiced, furnishes the clearest evidence of the futility of artificial birth control

as a means of avoiding conception.

I feel that there should be some way to furnish protection to these Catholic mothers through the Catholic maternity hospitals. With their close approach to the family through nurse, social worker, physician and Sister, they could surely inform Catholic parents regarding the serious moral and physical consequences of using contraceptives. Such parents should know that, aside from all other aspects of the question, contraceptives must always be regarded as an uncertain method of preventing conception.

The folly of contraception is further emphasized by physiological and biological evidence that in normal mature women there are only three days in each menstrual period or cycle when conception is possible.

This definite establishment of periods of biological sterility and fertility may go a long way towards the solution of a grave socio-economic, not to say medico-ethical problem. While the law of biological sterility holds good in all cases, its application, in the present state of our knowledge, is more or less impractical in about 10 per cent of women, owing to the excessive variations in their menstrual cycles. A more accurate determination of the application of the law is hampered by the lack of a sufficient number of records to determine accurately these cyclic variations.

The Catholic Maternity Centers

which I have suggested would be the ideal units for collecting, interpreting and dispensing the clinical facts needed to establish more precisely the practical application of this law of biological sterility. Moralists have set forth

clearly the indications for the use of this method by Catholics. It remains for us to initiate the study of the medical aspects of the question, and thus make a very real contribution to medical science and to Christian sociology.

CONGREGATION DE NOTRE DAME DE L'ASSISTANCE MATERNELLE

350, rue de Vaugirard, Paris

The Congregation of Notre Dame de L'Assistance Maternelle was founded in 1857 by a doctor who, being a widower, entered the priesthood.

He therefore knew by experience what a big help a nun would be in a family where the mother has to stay in bed because a new baby is expected.

The founding of that Congregation also answered a need of the moment in France, where, due to the modern unbelief spreading over the country, parents often neglected to christen their babies in case of danger.

In France, the nuns get their State diploma and their diploma for children's nursing, but all their experience comes from a prolonged stay in their "maternity" where they learn about the service to be given to the mothers and where they assist at all the births.

This "maternity," founded 30 years ago, now much larger and absolutely modern, accommodates

about 450 mothers a year—the poor and those in moderate circumstances. All services are rendered by the nuns under the control of doctors and midwives.

Through their training, they become very skilful in their profession and they specialize particularly in the care of premature children, who could not live without special supervision and care.

A nun thus trained is able to be sent alone to a family, where she stays as long as they need her, and usually leaves the mother only when she has fully recovered. The nuns are paid by those who can afford it (about \$2.00 a day), and this enables them to give free care to the poor and even to give them such help as layettes, cribs, etc.

For several years dioceses have been asking for "foundations"—and the country doctors, where our nuns are sent, would like to keep them for "maternités" which they have founded themselves, but we cannot fulfill all these demands.