Department of Maternal Welfare

PROVISIONS FOR MATERNITY CARE IN THE UNITED STATES*

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A DISCUSSION of provisions for maternity care in the United States seems to divide itself, logically, under the following headings:

First.—Our status in terms of our maternal mortality.

Second.—The possible bearing upon this mortality of the numerous and varied nationalities in this country and the distribution of population.

Third.—The means, (outside of private practice) through which the medical profession gives or directs maternity care, these being chiefly: (a) Hospitals, (b) Organizations other than hospitals such as the government appropriation, maternity centers, prenatal clinics, health centers, etc., (c) Public health nurses, and (d) Midwives.

Fourth.—The general results of the above work, the trend and further needs.

MATERNAL MORTALITY

In the matter of maternal mortality, the United States makes a poor showing. Childbirth still stands next to tuberculosis as a cause of death among women fifteen to forty-four years of age. Among twenty-two countries giving information, only two, Belgium and Chili, have a higher maternal death rate than we. Our maternal deaths have actually tended to increase, rather than decrease, during the past quarter of a century. In the death registration area, in 1900, the rate per 100,000 population was 13.4; in 1922, 15.6. Somewhat more reliable figures than these, though covering a shorter period, are the following rates per 1,000 live births in the birth registration area from the date of its establishment, in 1915 to 1923:

Deaths per 1,000 live births in the birth registration area, 1915 to 1923.

	1915	1916	1917	1918	1919	1920	1921	1922	1923
All puerperal causes	6.1	6.2	6.6	9.2	7.4	8.0	6.8	6.6	6.7
Puerperal septicemia	2.4	2.5	2.7	2.5	2.5	2.7	2.7	2.4	2.5
All other puerperal causes	3.7	3.7	3.9	6.6	4.9	5.3	4.1	4.2	4.1

In 1921, when the rate was 6.8, there was a total of 18,280 maternal deaths or one mother lost for every 147 babies born. A very large proportion of all these deaths have been from preventable causes. This in spite of the fact that in no country is there to be found better obstetric work, better teaching of medical students and nurses or better results among patients under good care. Evidently an explanation of this paradox would get at the root of our problem.

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As to nationalities, practically every nation on the face of the globe is represented among the 110,000,000 inhabitants of the United States, the size of some of the larger groups being estimated as follows:

Negroes	10,463,131 (9.9%),	or practically 10% of the entire population.
German and Austrian	10,389,790 (9.9%),	" " 10% " " " "
Irish	4,136,395 (3.9%),	" " 4% " " " "
Russian	3,871,109 (3.7%),	" " 4% " " " "
Italian	3,336,941 (3.2%),	" " 3% " " " "

In round numbers, 30 per cent of the population of the United States is of foreign stock, which means that they are either foreign born themselves or of foreign born parentage. Add to this the 10 per cent of native born negroes and we have only about 60 per cent of the population composed of native white stock. There is a fallacious impression widely current, that New York is an American city. The fact is that it is a veritable Europe, Asia, and Africa all rolled in one. Eighty per cent of the city's population is foreign stock, being composed of something more than fifty nationalities. For example:

German and Austrian	18.1%
Russian	17.5%
Italian	14.3%
Irish	11%

Many of the foreign groups establish communities patterned after their native towns, with churches, shops, theatres, and clubs preserving the customs, even dietaries of the fatherland. The result is that within the limits of one city one finds an almost endless variety of living conditions.

Advice upon matters of health and hygiene offered to people of such different habits and ideas is not likely to be acted upon uniformly. Accordingly, health education spreads slowly among the people who have migrated to America in body, but who, in spirit, abide by inherited traditions. On the other hand in such a city as London, where 95 per cent of the population is British, health teaching is given to people with so nearly the same inherited traditions that it may be expected to produce somewhat uniform response.

The differences in national background among our people seem to have a bearing upon our national maternal death rate. Among native born white women the death rate is 6.4 per 1,000 as compared with 10.8 per 1,000 among negroes. For mothers born in Ireland the rate is 9.1; Great Britain, 8.1; Canada, 7.9; Hungary, 7.1.

It is not entirely clear why there should be so much higher mortality among transplanted white women than the native born whites, but among negroes the risks of child bearing are increased by the prevalence of venereal diseases and rachitic pelves along with their poverty, ignorance, and generally poor condition.

But this diversity of peoples is not all. Apparently the distribution of the inhabitants also has a bearing upon our maternal mortality. Virtually all of the large and many of the small cities are well supplied with efficiently conducted medical and relief agencies to promote the well-being of their inhabitants. Contrasted with these well equipped if crowded cities are great areas of sparsely settled plains, prairies, deserts, and mountain country where the nearest doctor is perhaps 100 miles away. In such a state as Texas, for example, covering nearly 266,000 square miles (more than twice as large territorially as England, Ireland, Scotland, and Wales)—there is one county of over 900 square miles with only 67 inhabitants, but the physical needs of these remote people are the same as among city dwellers.

In a backwater of civilization in the Southern mountains, there are 5,000,000 primitive people who live today under practically the same conditions that surrounded their colonial ancestors two or three hundred years ago. Very often their only mode of travel is by horseback over a narrow trail, or up the bed of a mountain stream. As medical protection of any kind is practically unknown in many of these districts, the women fare badly in childbirth. Their attendants may be untrained neighbors, friends, grandmothers, husbands, workmen, or perhaps there may be no one at all present.

Curiously enough, the only obtainable figures suggest that women in rural communities have a brighter prospect of living through childbirth than urban dwellers, the rates being 7.7 per 1,000 live births for cities and 5.9 for rural districts. The probabilities are however, that the apparently high rates in cities are largely due to more accurate certification of death in municipalities, and the fact that because of education and automobiles, complicated cases are frequently removed from outlying districts to hospitals in the cities. But notwithstanding these figures, the real evidence is that city mothers, in general, have better obstetric care than rural mothers and that isolation and inaccessibility constitute something of a menace to life and health of maternity patients.

FACILITIES FOR CARE

Maternity Hospitals.—Maternity hospitals perform the twofold service of offering facilities for the care of patients and the teaching of student doctors and nurses. So far as I am able to discover, a satisfactory scheme of work and teaching is carried out or attempted in most of the modern maternity hospitals and wards. Although it may be adjusted to the needs, size and facilities of different hospitals, the essentials are much the same the country over.

There is a growing tendency among women in cities to go to hospitals for delivery. In 36 of the largest cities from which information was obtained, a total of 56 per cent of the births occurred in hospitals. In San Francisco the proportion was 85 per cent; Minneapolis 62 per cent; Washington 56 per cent; Fort Wayne 52 per cent. A comparison of the extent of hospitalization in cities and rural communities is found in Maryland. In Baltimore, the one large city, 18 per cent of the births were in hospitals and only 4 per cent in the rest of the state.

Maternity Organizations.—It is common knowledge that for at least a quarter of a century the patients of high grade obstetricians have been given efficient care and have profited by it; but until fairly recently even the best obstetricians began their care late in pregnancy and high grade facilities were so limited that good care was accessible to only a small proportion of women; too small by far to affect the maternal mortality for the country as a whole. However, with increasing recognition of the value of complete prenatal care, started early, provisions for giving this care, under reliable auspices, have been devised. It is not possible to ascertain the number of hospital beds, throughout the country, available for maternity patients today, but we do know that the number of maternity hospitals, wards and dispensaries has increased steadily during recent years; and organizations, other than hospitals, have been established to provide or secure competent supervision and care from the beginning of pregnancy throughout the puerperium.

In order to standardize maternity service for the country at large the Washington and Regional Conferences on Child Welfare adopted, in 1919, certain minimum standards for public protection of the health of mothers. Maternity centers which follow all or part of the suggestions for prenatal care contained in these recommendations have increased steadily in number and scope the country

over. In some instances the organization is devoted solely to maternity service and in others maternity service forms a part of a general health program. An interesting development of organized prenatal work is under way at the *Brooklyn Maternity Center Association.* In addition to conducting free clinics, the Association provides prenatal care and instruction for women in moderate circumstances through its *Mothercraft Club* in which a small fee is charged for membership, and in cooperation with the Brooklyn Institute of Arts and Sciences, it has inaugurated a course of lectures on maternity and child care.

Maternity and Infancy Act.—An important factor in providing adequate maternity care throughout the entire country is a fund appropriated under the Sheppard-Towner Act of 1921, entitled *An Act for the Promotion of the Welfare and Hygiene of Maternity and Infancy.* This law was enacted as a result of the efforts and country-wide educational work of the Federal Children's Bureau strongly supported by individuals and groups of doctors, club women, social workers and the press. In all parts of the country the fund has given an impulse to official effort to provide or make available for all expectant mothers not in the care of private physicians, prenatal care, safe delivery and protection during the puerperium. On June 30, 1923, forty-one states were operating under the act, through official state bureaus. Although each state conducts its work to meet its own needs the general method employed by all is to stimulate local interest and initiative through education as to the value and feasibility of good maternity care, and to give temporary aid in establishing work to be maintained ultimately by local funds. Special effort is made to extend to rural communities the kind of service and facilities that have proved effective in urban districts.

Concerning the work itself we find that although there are health conferences or centers for infants and preschool children in 36 states, there are *maternity conference centers* in only 31. Evidently the importance of maternity care is not as widely appreciated as the value of child care.

The proportion of expectant mothers attending prenatal clinics in 22 cities giving figures for 1923 varied as follows: In only one city less than 1 per cent of the maternity patients had prenatal care: in five, from one to five per 100: in four cities, from five to ten per 100: in seven, from ten to fifteen; and in five cities more than 15 out of every 100 expectant mothers were under supervision. (Utica 15.5 per cent; Providence 15.6 per cent; Minneapolis 18 per cent; San Diego 26.1 per cent; New Haven 27 per cent.)

Official provision for safe delivery has not kept pace with prenatal work. It seems to follow in the wake of educational work along prenatal lines and at present is found in comparatively few states. In some states effort is made to help the doctors who deplore the difficulty of performing clean deliveries in isolated homes. The Divisions of Child Hygiene have prepared model obstetric packages containing the minimum supplies for a normal delivery at home. The supplies are made from materials obtainable at practically any retail store and may be prepared by any woman of average intelligence.

Official provision for adequate postnatal care is negligible. A few states are encouraging the establishment of bureaus through which domestic helpers may be obtained for a moderate wage by young mothers who are confined at home. This affords relief from anxiety and responsibility about meals and housework, thus insuring rest during the puerperium which would otherwise be impossible for many women.

Public Health Nurses.—In many cities, towns and rural communities where there are no maternity clinics, public health nurses manage to give prenatal supervision through one means or another,—always, of course, under medical direction. The National Organization for Public Health Nursing (1923) reports 206 volunteer

agencies, each employing more than three nurses, a total of 2704 nurses, giving prenatal service in 196 communities in 41 states. Some 2,000 volunteer agencies, each employing three or fewer nurses, either definitely offer prenatal nursing or will respond to requests from doctors for such service. The Organization states that prenatal nursing service is extending so rapidly, particularly in rural communities, that the newest figures available are always far behind the real situation.

Midwives.—Whether we are looking forward or backwards upon this question of provision for maternity care we cannot, with intelligence, ignore our so-called midwife problem—a situation, by the way, that is incomprehensible to Europeans. In all civilized countries, except the United States, the midwife is frankly acknowledged to be a factor inevitably operating for or against the welfare of mothers and babies. In their interests she is trained, licensed and restricted.

It is practically impossible to obtain exact information about the extent of midwives' work in America, but there are not far from 50,000 women, loosely described as midwives, attending perhaps 20 per cent of the births throughout the country. In certain New England states they are almost unknown, as in Vermont, where there are only seven all told. But in some sections, particularly the South, the magnitude of the problem alone constitutes a menace. This is indicated by the following figures upon the proportion of births attended by midwives, and the estimated number of women practicing.

In St. Louis	midwives	report	44 per cent of all births.
New Orleans	"	"	80 per cent " " "
New Mexico	"	"	40 per cent " " "
In Mississippi	4,000	midwives	attend 48 per cent of all births.
Alabama	1,500	"	" 60 per cent " " "
Virginia	6,000	"	" 40 per cent " " "
Georgia	5,000	"	" 20 per cent " " "
Kentucky	2,500	"	" 20 per cent " " "
Maryland	2,000	"	" 66 per cent " " "
North Carolina	6,500	"	" 73.5 per cent of the negro births.
South Carolina	5,000	"	" 80 per cent of negro and 20% of white births.

Midwife Training.—So far as one can learn, there is in the entire country but one veritable school for midwife training, connected with a hospital of undoubted standing, in which the pupils are resident, namely, the Bellevue School for Midwives. It was established in 1911 through the combined efforts of the hospital trustees and the New York Committee for Prevention of Blindness. This school is for untrained women, not nurses, and has graduated about 450 midwives. In Philadelphia, the Maternity Hospital and the Preston Retreat will accept applicants for midwife training, but both schools have graduated only about a dozen pupils all told. Some state and local departments of health greatly improve the work of midwives practicing within their bailiwicks by means of supervision, lectures, and demonstrations by doctors and nurses under official auspices; but except for the graduates from Bellevue and two Philadelphia schools, most of the midwives in the United States who approach competency were trained in European schools before coming to America. The excellent work done by many of the trained midwives makes us realize how terribly defrauded are the patients who are attended by unqualified women, particularly in rural communities.

For many years there have been nurses engaged in rural work, (who inevitably perform deliveries among uncared for rural mothers) who have wanted to take midwife training, but there has been no school with a definitely organized course in connection with a maternity hospital, where such nurses could go for this training. As a result of this inconsistent situation, three American nurses have gone to London during the past year and entered schools for midwives.

Midwife Control.—So far as official control is concerned, there is no effort in 9 of our 48 states to examine, register or control midwives, much less train them. Any woman who wishes, therefore, may practice unmolested in Maine, Michigan, Nebraska, South Dakota, Texas, Vermont, West Virginia, Wyoming, and Massachusetts. Although the midwife does not legally exist in Massachusetts the registrars of vital statistics are so aware of her presence in the flesh that they pay her twenty-five cents for each birth certificate she files. These officials, in 22 Massachusetts towns and cities give the names of 137 midwives who were paid from state funds for reporting 2,723 births in 1922.

In 17 states there are no state-wide requirements but midwives are supposed to register with a local authority. In 22 states there are irregular requirements for state permission or licensure to practice but in only four of these, New York, New Jersey, Pennsylvania and Connecticut is there anything like satisfactory control of the practice.

The last word in safeguarding mothers and babies will not be said until, in every state, there is adequate provision for training and controlling those who attend these patients, no matter by what name they are called, nor until it is made impossible for untrained people to practice midwifery "habitually and for gain."

GENERAL RESULTS AND FURTHER NEEDS

We have considered the details of provisions for excellent care of maternity patients in hospitals; taken a look at the aims and results of prenatal clinic work as well as government provisions for safeguarding the lives of mothers and babies; paid respectful attention to figures telling how many nurses and midwives are doing what in how many states, and mulled over some dry as dust data about what happens to whole and fractional mothers in lots of a thousand.

We perceive that maternity hospital facilities are increasing and the standards of work are improving; doctors and nurses are being trained in increasing numbers; a start is being made to give midwife training to graduate nurses while maternity specialists are becoming available to more and more of the remote and isolated communities. The general public believes more widely in the urgency and feasibility of good maternity care and is seeking such care with growing frequency. Should we stop just there we could all settle back with smiles of satisfaction and complacency.

But the truth is, as you and I well know, that this presentation of facts and figures, from a practical standpoint, is not worth the paper it is written on nor the time it has taken to read it. In years past, many papers—abler than mine, more scientific, possibly longer—have been written, presented and published; and the net result of it all is that there has been no appreciable reduction in our national maternal death rate in twenty-five years.

What is wrong?—We know, without help from tables of percentages that the obstetricians in this country can and do give life-saving care to maternity patients, and we also know that year after year an army of women in the prime of life are struck down and killed—or what is often worse are made lifelong invalids because they do not receive this care.

What is wrong?—The answer is so apparent it seems scarcely worth while to voice it.

Complete and skilful maternity care is not widely enough available in this country and the lay public is not as yet widely enough convinced of its urgency. We still have too few good doctors and too many poor ones practicing obstetrics. Too few well trained maternity nurses and midwives. Too few hospitals and other agencies provide complete maternity care to patients, and facilities for training to doctors, nurses and midwives.

The remedy is education. The attitude back of this education, in my judgment, is the heart of the whole situation.

Every detail of maternity work that is done, east, west, north and south must originate in and be guided by the medical profession. From managing the ponderous machinery of government organization down to bathing the eyes of a baby in a remote mountain cabin, the entire scheme is the application of medical teaching—application to the individual mothers and babies of the practices that the medical profession has demonstrated, will safeguard the lives and health of these patients.

What we need is not that the high peaks of obstetric work in this country shall be higher, making it possible to save a few mothers from rare complications, but that the average of the care given to all patients shall be raised. That every expectant mother shall be taken seriously. That every detail of the care and supervision of even normal cases shall be regarded as of such importance that it will be performed earnestly and conscientiously. That those in high places give high value to obstetric practice is not enough. The whole question needs to be exalted in the minds of the many to the plane it now occupies in the minds of comparatively few. By precept and example, every student and every nurse should to be so impressed by the dignity and enormous importance of all obstetric work that their attitude will be communicated to others, patients included.

Wherever really good work has been done, in the cities or country, we find that those who are doing it have not only knowledge and skill but a spark of something else—call it devotion, reverence, what you will—but something that characterizes the work with dignity and respect. When one considers the scope of obstetric practice—how necessary are skill, resourcefulness, insight, and sympathy—it may well challenge the most and the best that one has to give.

Education then. Education that fires and drives and inspires, from the medical profession down through its various assistants and the laity.

Education that will so impress every human being with the urgency and feasibility of good maternity care, that will be demanded and given in every case. Education in its broadest, completest sense will inevitably go far toward reducing our utterly wicked, needless loss of mothers and babies.

Publications from the following sources of information have been consulted: the Federal Children's Bureau, United States Public Health Service, United States Census Bureau, American Public Health Association, American Child Health Association, National Organization for Public Health Nursing, Statistical Department, Metropolitan Life Insurance Company, Pennsylvania Bureau of Medical Education and Licensure, Henry Street Nurses' Settlement.

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(*For discussion, see p.* 723.)

NEW YORK ACADEMY OF MEDICINE

SECTION OF OBSTETRICS AND GYNECOLOGY

MEETING OF JANUARY 27, 1925

MISS CAROLYN C. VAN BLARCOM presented (by invitation) a paper entitled **Provisions for Adequate Maternity Care in the United States.** (For original article, see page 697.)

DR. FLORENCE MCKAY, Albany, N. Y., presented (by invitation) a report on **What New York State Is Doing to Reduce Maternal Mortality.** (For original article, see page 704.)

DR. AUSTIN FLINT discussed **The Responsibility of the Medical Profession in Further Reducing Maternal Mortality.** (For original article see June issue.)

DISCUSSION

MISS ALTA DINES.—The Association for Improving the Condition of the Poor was incorporated in 1843, pledged to care for the health, as well as the other family welfare problems of those who came under its care.

For many years the work was done by volunteer workers. Then in the nineties they began having paid workers; but these visitors soon discovered that they really didn't know enough when there was pregnancy; what to advise the mothers as to their proper care. Therefore, in 1907 this organization started prenatal work, the first, I believe, in New York City.

Pregnancy has always been a very prominent problem to meet in family welfare work. In 1925, out of 5,106 families cared for there were 1685 expectant mothers, or about 37 per cent of those families.

In the Italian section we have a population of about 35,000 people, and during 1923, it was found that 77.3 per cent of the deliveries were midwife deliveries. This indicated a very special need for prenatal work. The A. I. C. P. nurses gave to 58 per cent of those who were delivered of babies, prenatal care.

In the colored district there is a population of about 50,000. Here 94 per cent of the mothers delivered of babies were under the care of the A. I. C. P. for prenatal service. There is a very special problem there, namely, the great complication of venereal disease, and of the total number of births in that district almost 25 per cent of the women had syphilis. Here we have a different picture. Only 1.7 per cent of those colored women are delivered by midwives; 94.2 per cent are delivered either in the hospitals or by the outpatient services of the hospitals. We have had startling results. The mortality rate has decidedly decreased in the colored district. In the Italian district the maternal mortality was already low, but there has been an improvement of 10 per cent in the infant mortality in that district in five years. They did need and they do need to be taught how to care for the babies when they come into the world. Of course, the stillbirths and other difficulties coming from syphilis have been very marked in the colored district.

DR. FREDERICK W. RICE.—I do not think there is any question that those who have studied this matter of reducing the high maternal mortality, will agree with Dr. Flint when he says that education of the public must come first, and then, with the education of the public in this subject and the demand for better maternity care, will follow educated medical attention in these cases. However, I disagree with him when he says that we can get immediate results through the medical profession by giving them standards in the management of the normal case. I think it is a very difficult thing to educate the public, and I also think it is a very difficult thing to educate the large part of the profession, now practicing, to limit their practice to the normal case and avoid operative interference. I think the way it is now being attacked is going to give results in the next five or ten years, that is, by means of the work that is being done through the states, by the Sheppard-Towner Bill organizations such as the maternity centers and organizations connected with other welfare associations. It is through such agencies, through nurses reaching the mothers, that they are going to realize the importance of carrying out the rules of hygiene in protecting them through pregnancy.

As far as sepsis goes, I think it is going to be some time, simply from the

fact that none of these organizations, state, federal or local, has anything to do with the actual delivery of the case. They can protect the mother through pregnancy and tell her how to take care of herself so as to avoid toxemia of the severe type but when the actual delivery comes, that is when sepsis occurs. In the last ten or fifteen years, in England, where the number of midwives has increased perceptibly, the number of doctors called in by midwives is increasing all the time, and I think, until we actually supervise and weed out these ignorant women who are practicing in the Southern states and the scattered districts, we are going to have a continuously high sepsis rate. I believe that work can only be done through trained nurses, but much differently trained than the nurses described by Miss McKay. They must go out not as midwives, but as instructors of midwives, and I think until that time comes we will not get results.

DR. HAROLD C. BAILEY.—It occurred to me while Miss Van Blarcom was talking about the differences of nationalities and of distances in our country compared with others abroad, that that possibly offers a very easy explanation for us, but, as a matter of fact, from actual figures in our own state, we find we are 20 points below some others in the United States Government registration area. Therefore, we can hardly claim that the mountain whites and the colored women increase our mortality as much as we would expect that they do, and therefore we will have to find some other way to explain this high rate.

New York is the best city, or was, in the last two or three years, in the country according to the records, as regards maternal mortality and still the rest of the state has a figure which is considerably higher. Consequently if our teaching only takes care of those immediately about it, we are doing very little good.

There is another point, namely, the division of the responsibility. We have, of course, the midwife, the doctor, and the hospital. Here in our own town we have reduced the incidence of midwives from 40 to about 20 per cent within the course of a few years, the last report showing that there were only 27,000 midwife deliveries in the city as against some 49,000 ten or twelve years ago; so it would seem as if the midwife, as a problem in this particular city, did not enter very much into our discussion. At any rate, she is a recognized and supposedly trained person, and she handles only normal cases.

I think there is no question that the doctor who practices general medicine and takes obstetrics as a side issue is the man at fault to a very considerable extent, and if we follow what Dr. Flint has suggested and demanded, or if the public follows and demands what he has suggested, namely, that surgery be done by surgeons, we very likely would have the abnormal and delayed labor cases removed to the hospital for care by those who are trained and competent to handle such cases.

DR. FREDERIC C. HOLDEN.—Notwithstanding our improved educational facilities, prenatal care, theoretical and practical training, we have increased our maternal mortality. Why? A large group of medical men will never be obstetricians. They know the theory of obstetrics, but they have no mechanical common sense to make a combination of the theory and the practice.

DR. RALPH W. LOBENSTINE.—Regarding medical education: in the first place, all medical students should be taught the value of prenatal care, even though the maternal mortality has not improved. I myself question that fact despite our statistics. I think maternal mortality has improved and that the reason it apparently has not improved is because we are getting more accurate statistics. Secondly, Dr. Flint brought out that conservatism is the point that

the medical student and the older doctor must always have in mind, unless he is a specialist, and he should practice conservatism up to a certain point, but you cannot compare the work of the specialist and the internist in obstetrics any more than you can in surgery. Third, in order to improve medical teaching you must have more autopsies, particularly of babies.

Just a word from the public health standpoint. In rural communities the greatest blessing, as I have often said before, outside of the doctor at the actual delivery, to the poor woman, is the nurse. If you get outside of this small environment of ours, where we have every facility, and that of cities like Boston, Philadelphia and Chicago, the facilities are very bad, and that is true of all rural centers where we have great distances and few doctors, and under such conditions what is a poor woman to do unless she has a nurse there to help? If she cannot get the doctor she must have some member of the family to help her out. The next step in attacking this problem in the rural districts is in the specially trained nurse, or the nurse trained in a specialized subject like obstetrics.

One or two things must happen in the country if conditions are going to improve. We must have nurses, with an obstetric training to help out the doctors in those districts. It is all very well for us to say that the communities have plenty of doctors and the roads are good and doctors have automobiles and they can get to the patients. They cannot do it. Miss McKay will tell you that they cannot do it, despite reports to the contrary. If you have scattered throughout the country certain groups of these specialized nurses who can get to the patients when the doctor cannot and will stay there until the doctor arrives, conditions may be improved.

The third and last thing that I want to touch upon is this: if you can get more hospitals to serve two or three counties where the population is not large, then with a system of motors, etc., you can get the abnormal cases easily to the hospitals and thus improve conditions.