

EXTENDING THE CARE OF  
PREGNANCY \*

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The question of prenatal care, or in other words, the supervision of pregnancy in the interest of mother and child, is attracting a great deal of attention. Have we any new measures to report? Has the laboratory or the clinician recently brought to light novel methods of therapy or prophylaxis? As a matter of fact, very little has been added to what has been known for years about the care of pregnancy.

Yet some groups of women in this country are benefiting by good prenatal care and their mortality rate and that of their infants is being lowered, while the greater number suffer from inadequate care and the mortality statistics show the humiliating results.

For twenty years the death rate from childbirth for women in America has not decreased.<sup>1</sup> Meanwhile, many formidable diseases have yielded to medical science and claim fewer and fewer victims. Tuberculosis, typhoid, diarrheal diseases of infancy and diphtheria all show lower death rates, the latter a reduction of 50 per cent. It may be justly said that more new measures have been brought forward for the treatment of these diseases. Nevertheless, the means already at our command, if we employed them generally, could reduce this mortality of mother and child. Among sixteen enlightened nations we rank fourteenth. Only Switzerland and Spain come lower on the list. Sweden has a death rate of less than half of ours.

## REGULATION OF MIDWIVES

For some reason, women in America receive bad obstetric care. Yet physicians attend the confinements in America more generally than in the European countries. This is not a country where the midwife flourishes. In the larger cities, where there are extensive foreign populations, there are many midwives. In New York, for example, they still attend about one third of the confinements. However, you do not hear so much in New York about the midwife menace as you did formerly. We still have the midwives, but they are no longer such a menace. Jacob Sobel, chief of baby welfare, New York Department of Health, says of the midwives:<sup>2</sup>

The fact is that in comparison with our medical confrères, the midwives are listed on the credit side of the ledger as this relates to the percentage of deaths from puerperal sepsis, from stillbirths, deaths during the first week of life and cases of ophthalmia neonatorum.

This has not always been so. But the midwife has been regulated and closely watched. She has been taught just how far she must go and when she must call for medical assistance. Moreover, in what she is permitted to do, there are certain measures she must take, on penalty of losing her license. In other words, she is policed. The doctor is permitted to learn the right and wrong in obstetric practice, but he is policed only by his own conscience.

\* Read before the Section on Obstetrics, Gynecology and Abdominal Surgery at the Sixty-Ninth Annual Session of the American Medical Association, Chicago, June, 1918.

1. Meigs, Grace L.: Maternal Mortality from All Conditions Connected with Childbirth; U. S. Dept. of Labor, Children's Bureau, Bureau Publication 19, p. 17.

2. Sobel, J.: Supervision of Expectant Mothers, New York Med. Jour., 1918, 107, 108.

In America, where the practice of midwifery is in the hands of the medical profession, the doctor must bear the stigma of the bad record. It is the doctor who must institute the measures that will raise the standard of this branch of practice.

## PRACTICAL GAINS FROM PRENATAL CARE

It has been shown that prenatal care will diminish maternal mortality and morbidity, and will lessen the number of infant deaths in the first month of life, and the number of stillbirths.

The Committee for the Reduction of Infant Mortality of the New York Milk Commission, in about 3,000 cases which were closely supervised during pregnancy, report a 69 per cent. decrease in maternal mortality, a 28 per cent. decrease in deaths of infants under 1 month, and a 22 per cent. decrease in stillbirths.<sup>3</sup> Davis,<sup>4</sup> Lobenstine,<sup>5</sup> Emmons,<sup>6</sup> and many others show favorable results.

The women are willing to be supervised. At the John E. Berwind Free Maternity Clinic, we stamp on each applicant's card the dates on which she is to return for the prenatal clinic. If she does not come, we send a nurse for her. But most of the patients are responsive and there is already an attendance of from 150 to 200 a month at the prenatal clinic. Throughout the country wherever investigation of this subject has been undertaken, it has been found that the pregnant women eagerly welcome prenatal care. If this care of pregnancy will improve conditions, and the patients, when enlightened, are anxious to have this care, it is our duty to provide it.

## STANDARDS OF PRENATAL CARE

We must first arrive at a standard of what we consider satisfactory care. Dr. J. Whitridge Williams has prepared for the Children's Bureau of the Department of Labor, the following fair standard of medical prenatal care:<sup>7</sup>

1. A general physical examination including an examination of heart, lungs, abdomen.

2. Measurement of the pelvis in a first pregnancy to determine whether there is any deformity which is likely to interfere with birth.

3. Continued supervision by the physician at least through the last five months of pregnancy.

4. Monthly examinations of the urine, at least during the last five months.

The Maternity Service Association of New York, comprising practically all the Maternity Hospitals of Manhattan, has accepted as the minimum of prenatal care substantially the same standard, specifying also a blood pressure estimation at each visit and a Wassermann test in every suspicious case.

But more than 70 per cent. of the women of New York are cared for by private physicians or midwives and are not included in the benefits of this newly created standard.

## RURAL AND URBAN CARE OF PREGNANCY

The Children's Bureau of the Department of Labor has made a study of obstetrics in the rural districts.<sup>8</sup>

3. Report of an Experiment in Prenatal Care, 1912-1916, New York Milk Commission, 105 East Twenty-Second Street, New York.

4. Davis, M. M.: Relations of Prenatal and Postnatal Work, Boston Med. and Surg. Jour., 1917, 17, 264.

5. Lobenstine, R. W.: Development of Prenatal Care in the Borough of Manhattan, Am. Jour. Obst., 1917, 76, 392.

6. Emmons, A. B.: Prenatal care, Am. Jour. Obst., 1917, 76, 401.

7. Rural Child Welfare, Series 1, U. S. Dept. of Labor, Bureau publication 26, p. 28.

8. Meigs, Grace L.: Rural Obstetrics, U. S. Dept. of Labor, Washington, D. C.

In one district in a prosperous community, forty-eight of the fifty mothers interviewed had been attended by a physician at their last confinement. Only seven of the fifty mothers had had any prenatal care by a physician, one visit being paid in each case; and only three had had urinalysis.

In another section, a plantation district in the South, of fifty women interviewed, twenty-six were white and twenty-four colored. Only ten white mothers were attended at their last labor by a physician. Fifteen white mothers and all twenty-four colored women were attended by colored midwives. These midwives were not licensed, trained or supervised.

In some of the larger cities, well organized movements are now under way for the better care of pregnancy. Maternity centers are being established by various agencies, through which prenatal care is provided for the women without prejudice to the physicians, midwives or hospitals who may be chosen to attend them in the coming confinement. The various health boards have joined in this work. In the borough of Manhattan, a zoning system has been arranged so that each hospital limits its service to an area in its immediate neighborhood, making it easy for the patients to come to the clinics for consultation and examination or for the prenatal nurses to visit them. In Zone 7 an intensive study is being made through the efforts of several organizations and a house to house canvass for pregnancies is made to secure complete early registration. It is evident that certain women are to be favored by better supervision.

Our purpose must be to extend the care of pregnancy to all classes of women in the cities, towns, villages and rural districts. Some progress has been made by certain townships through local visiting nurses' organizations, mothers' meetings and other useful agencies. At the most, however, we can say only that a little progress has been made here and there.

#### A NATIONAL PROBLEM

The problem is complex. Moreover, it is immediate. At the present time, we are painfully awake to the necessity of conservation of life. Over 15,000 women are lost in the United States each year in childbirth. Many more lose their future efficiency from the same cause through invalidism. Of all the deadly diseases only tuberculosis claims more victims among women of child-bearing age. It would seem that this is a national problem.

We find the statement made by the most earnest of the investigators of this subject that it would be impossible to extend intensive supervision of pregnancy throughout the land on account of the cost. But why reckon the cost? There is, if we consider the loss of mothers, the stillbirths and the deaths of infants under 1 month, a probable salvage of 75,000 lives annually. Every woman confined in the United States could have one week's trained nursing at a cost of \$60,000,000. We are in an atmosphere of war costs and have been educated to colossal expenditures. We are no longer staggered at an outlay of \$6,000,000,000 for heavy artillery.

This matter of reducing obstetric mortality is properly a war measure. Obviously I do not propose the furnishing of a nurse to every confinement patient at government expense, but have quoted the cost for comparison with other war expenses.

Sooner or later, we shall have a national board of health and a medical cabinet officer. Let the government begin with a national commission to conserve motherhood. Let this commission be empowered not only to study the question and to organize cooperation among existing agencies, but to spend money in creating a system of rural nursing. Let it create and train a body of government nurses. Let it establish, if it sees fit, prematernity hospitals for the reception of patients requiring close supervision and too remotely placed to obtain it. Let it furnish the money necessary to extend the work of organizations working along the same lines in the cities and towns. I shall not attempt in this brief paper to sketch a plan for the details of this work. But great as is its scope, it is not too large a problem for the resources of this nation, nor for the genius of the medical profession. This society should take the initiative and its members are the best qualified to plan the work and to carry it out. Undertaken as a measure to economize life in this crisis of sacrifices for self-preservation, it will survive to ease the trials of womanhood when, once free from our torments, we may feel again the purpose of making life beautiful.

#### THE PHYSICIAN'S GAIN

The physician as an individual will lose none of his dignity nor his benefits if women receive this additional care of pregnancy and parturition. On the contrary, the importance of obstetric care will be realized, as education on this subject is spread. He will be called on to give more of his time and he will be paid for it. As the knowledge grows that the attendance of pregnancy and labor and the guarding of young infant life is a great and important scientific function, the market will be created for good obstetric care and the practice of midwifery will be worth while. Doctors will no longer take cases reluctantly for reasons of policy, realizing as they take them, that if they give all the attention the subject demands, they are donating two thirds of their services and being paid for one third. Also, according to economic laws, when the demand is created for higher efficiency, and more careful service, the supply of good midwifery will be forthcoming. A national measure for the supervision of pregnancy will create the demand. This society should not delay in taking the steps to inaugurate this movement. It is inevitable that when our country comes to count its losses and searches for places at which to save, this great gap from which so many lives are leaking will not be overlooked. We should be the first to recognize and repair it.

Let the American Medical Association ask for a national commission to promote the care of childbirth as a war measure, with appropriations of money commensurate with the importance of the work according to the standard of other war measures.

Then let the United States, through the efficiency of the medical profession, take its place as leader among the nations in the care of childbirth. We are fighting to make America a safe place in which to live. Let us make it a safe place in which to be born.

#### ABSTRACT OF DISCUSSION

DR. WILMER KRUSEN, Philadelphia: In Philadelphia we are trying to convince the municipal authorities of the necessity of appropriating money for the Division of Child Hygiene which has the supervision of prenatal work. When, however, we listened to the broad program presented by Dr.

Hill we see that the question is not one of municipal, county or state, but really an international problem, because Dr. Hill wants to remove from the United States the stigma of being the fourteenth on the list in regard to the mortality of the mother and bring us up to the first place. The necessary information and influence to inspire our government to this action must be found in the 144,000 or more members of the medical profession, many of whom are members of this Association. No work is more important. It is just as important to conserve the life of the mother as that of the newborn child. The Children's Bureau of Philadelphia is seeking to save at least 100,000 of the 300,000 children who die before the sixth year.

DR. J. H. CARSTENS, Detroit: We can accomplish this work in various ways. We now teach better obstetrics than we have in the past. We are requiring that students actually attend cases of confinement, and they are learning the details of the management of the work. In the college with which I am connected we require the student to attend twelve cases and to keep an accurate record of the details. The midwife does not seem to have a large number of infant mortalities. This, however, is only apparent, and it must be remembered that in a serious case the midwife calls in a physician. He has to sign the death certificate and gets the blame. It is a matter of education of the public. We must agitate the question until boards of health and nurses educate the people so that every woman may know that when she is pregnant (although the process is a physiologic one), it may become a very serious surgical case and that she should consult a doctor. Of course, to educate the people necessitates the help of boards of health, nurses and investigators of all kinds. The suggestion made by Dr. Hill of having the United States take hold of the matter seems eminently proper. If the United States can afford many thousands of dollars to take care of hogs it certainly can afford hundreds of thousands to take care of women and children. We should use our influence with our congressmen. If we do this we can probably get Congress to do something for the health of the pregnant women. Much could be done, as Dr. Hill has said, with a health officer a member of the cabinet. From him this work would radiate throughout the country and we should have in every district a health officer instructing the people in the matter of health.

DR. IRVING F. STEIN, Chicago: In Chicago we are doing much the same work as that described by Dr. Hill. At the Michael Reese Hospital we have a prenatal clinic in which we have seen as many as seventy-eight women in one morning. The clinic meets twice a week. The blood pressure and urinalysis is taken at every visit. The first visit comprises a complete physical examination, including observations of the thyroid, the teeth, the breasts, the heart, the limbs for varices, etc. We try to educate the women in the care of their teeth and in the wearing of abdominal supports. If they wear corsets, we show them how to wear them properly. The incidence of eclampsia has been markedly reduced since the inauguration of the clinic. The pathologic cases are recognized early, are sent into the maternity for observation and consultation, and cared for before they become "neglected cases."

DR. IRA L. HILL, New York: In my reference to the midwives I brought the matter up not to praise them but to show how much their work had progressed since they were under supervision. Regarding the investigations being made in Washington by the Department of Labor through the Children's Bureau, it is interesting to know that the greatest inspiration for any one who has had occasion to do any work in the study of prenatal statistics comes from that bureau, and that the two hundred and some odd thousand dollars which they have had for this work represents a tax of a third of a cent a year for all the inhabitants. Our government, therefore, could probably afford to spend considerably more and still not be working any injustice to the people.

**Experimentation.**—It is too often overlooked that for century after century Nature has been pitilessly performing her crude and cruel experiments and killing millions of human beings every year.—W. W. Keen.

## A NEW PRINCIPLE IN THE SURGICAL TREATMENT OF BRAIN TUMORS\*

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Craniotomy for brain tumor, with or without focal symptoms, not infrequently fails to disclose the neoplasm. The evidence of increased intracranial pressure will be manifest by various degrees of brain bulging, by a flattening out of the convolutions, by obliteration of the sulci and by diminished or absent brain pulsation. Inspection, palpation, and exploration by incision or aspirating needle all fail to locate or reveal the cause. The tumor may be so deep within the brain substances or at such a stage of development as to be inaccessible. The lesion may be an infiltrating glioma, which cannot be macroscopically differentiated from the normal brain, or the craniotomy may not have been formed at the proper site. The wound is closed, temporary benefit is conferred by the decompression, and in time the patient dies.

Definite localizing information may develop after decompression in cases in which focal symptoms have been absent. In these cases, patients have been not infrequently reoperated on and the brain tumors successfully enucleated. The cases with focal symptoms before operation, and those without, which do not develop localizing data after negative exploration, are considered hopeless and the patients are permitted to die. The necropsy shows the tumor, or no further investigation is made. My discussion is limited to this latter type, the "hopeless" case, which deserves further consideration and should not be given up, for the tumor may and can be removed at times, as illustrated in the following case from the University Hospital.

### REPORT OF CASE

CASE 11487.—E. L. B., a man, aged 29 years, was admitted to the neurologic service of Dr. A. S. Hamilton, July 8, 1917, on the application diagnosis of cerebral syphilis, complaining of excruciating headache, impaired vision, spastic paralysis of the left arm and leg, and general weakness. He had had several attacks of unconsciousness lasting from one to two hours. There was slight incontinence of the bowel and the bladder. The administration of potassium iodid and mercury had been followed by improvement of symptoms. The blood and spinal fluid Wassermann reactions were negative. Bilateral papilledema were present, more pronounced in the right eye ground. He had several typical jacksonian seizures while in the neurologic service, the attacks beginning in the left foot and extending up the body, involving the leg, the arm and the face. The diagnosis of cerebral neoplasm in the right rolandic area was made, and the case was transferred to the surgical service.

July 24, 1917, a large osteoplastic flap opening was made over the right motor area of the brain. When the dura was opened the brain began to bulge. The intracranial pressure was extreme, the cortical vessels were engorged, and the surface of the brain became smooth and flat, the sulci and convolutions being flattened out and obliterated. Inspection, palpation and exploration with Cushing's aspiration needle failed to disclose the neoplasm. Aspiration of the lateral ventricle was performed. The cerebral pressure was so great that the bone trap door had to be removed to effect a closure. The case was considered as being a deep-seated lesion or an

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