MATERNAL MORBIDITY AND MORTALITY IN THE UNITED STATES*

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IT is the individual who dies; there is no mass mortality in obstetrics until the records are filed.

The reiteration of statistics, in reference to facts with which we are all familiar, is wearisome and time consuming. The sins of omission and commission of all figures, which could be presented relative to maternal morbidity and mortality, are included in three sentences:

Maternal morbidity and mortality have not been reduced in the United States in the last twenty years; according to the census reports, 16,000 women die in labor annually.

In the loss of mothers, the United States stands fourteenth among the so-called civilized nations, only Spain and Belgium having a higher death rate.

Puerperal septicemia and eclampsia claim over one-half of all the patients who die. Oliver Wendell Holmes, in 1845, pronounced childbed fever "a private pestilence," and showed that it is preventable. Joseph B. DeLee, in 1923, gives records of 40,000 cases of labor in the Chicago Lying-In Hospital without a death from eclampsia.

The questionnaire of the Committee on Maternal Welfare of this Association, which was sent to every section of the country, contained a request for the views of our correspondents regarding the causes of maternal morbidity and mortality, and for suggestions as to possible remedies for their improvement. Valuable expressions of opinion were received, which could not be embodied in the Committee's report for want of space. So, when our Secretary, Dr. James E. Davis, wrote requesting a paper on this subject, the assignment was considered opportune.

To paraphrase the famous question of one of our midwestern literary lights, "What is the matter with obstetrics?" The letters received are so much in accord concerning the reasons for the opprobrium of obstetrics, that extracts from these furnish a comprehensive answer.

Since we are meeting in the great medical center redolent of the memories of Hodge and Meigs and Theophilus Parvin, it seems fitting to have the opinion of one of the present generation upon whose shoulders the mantle of those great teachers has fallen, Dr. Edward P. Davis, who writes in part:

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"In Philadelphia and vicinity, as far as I can observe, the condition of obstetric practice is essentially as follows: The rich obtain excellent medical care during pregnancy, parturition and recovery from labor. More of them go to hospitals for confinement than formerly. The interruption of pregnancy, accidents in labor, and bad recoveries, are more the result of dissipation, luxury and degeneration among these people than a lack of proper obstetric attention.

"The poor obtain excellent obstetric care if they enter hospitals. They have better attention than formerly in dispensaries, where a good deal of publicity is given to prenatal, so-called, care. . . . . Obstetric care is probably conducted among the poor with greater success than among any others, because they can be taken to a hospital more readily and are under better control. This results in the saving of lives, sometimes of doubtful value to the community. It does, however, secure a positive gain to the population by maintaining the health and working power of mothers, and by keeping the families together and helping the artisan in his domestic fortune.

"The population most in need of good obstetric care is the so-called middle class, with small and limited incomes but with sufficient intelligence, education and refinement to desire and appreciate good medical attention and privacy during illness. Such cannot afford expensive private rooms in hospitals nor the services of specialists, nor can they have high priced trained nurses. Our large hospitals lack greatly moderate priced accommodations for such patients. They are apt to consult general practioners who undertake confinements in apartments or private houses, without proper facilities, with more or less bad results as regards the health and strength of the mother and child.

"On the side of the medical profession, the middle class medical man, or general practitioner, so-called, is the greatest danger in obstetrics. A midwife, under strict control, does comparatively little harm, but the doctor who does obstetric work to get the medical practice of the family, giving as little time and attention as possible, because it pays but little, is the one responsible for many obstetric disasters. . . . . From the standpoint of the medical profession, it must be remembered that the struggle for existence is a bitter one. The doctor must take all he can get and do with it his best. He does not dare refuse obstetric operations because his competitors do them, and yet he cannot do them well. . . . . .

"On the side of the medical profession obstetrics must be considered a speciality of equal importance with surgery. Gynecology is naturally a department of surgery, and as obstetrics improves, the field of gynecology becomes a narrow one. The fact that large fees have been obtained by gynecological operations, and comparatively small fees are obtained in obstetric practice has resulted in the disproportionate importance placed upon gynecology."

Another teacher and leader, Dr. Franklin S. Newell of Harvard, says, among other things: "I would say that conditions in Boston are not perfectly satisfactory, owing largely to the fact, in my opinion, that a considerable proportion of the obstetric consultation in the surrounding towns and cities is done by the younger surgeons who have had no obstetric training, and whose one idea in delivery is to do a cesarean section, irrespective of the conditions present, and the needs of the individual patient.

"Also, that it is very difficult to educate the older general practitioner to the advantages of prenatal care, but we can impress our younger men. Prenatal care is so comparatively recent that the general practitioner of over forty-five pays little or no attention to it."

From the far south, Dr. C. R. Hannah, Professor of Obstetrics in Baylor University, Dallas, Texas, writes: "Too many of our medical men who do obstetrics

fail to comprehend and put into practice that which they know. Morbidity and mortality of mothers could be lowered if specialists in obstetrics were more frequently called. Surgeons are more often called than obstetricians. The lack of knowledge of obstetrics on the surgeon's part frequently leads to operations, rather than methods of obstetric procedure."

Dr. John E. Talbot, Worcester, Massachusetts, says in part: "I believe the public needs education on the value of good obstetric care. At present it is the least appreciated branch of medicine, even among the educated class. The fault of this situation is due partly to historical reasons, but mainly to the medical profession itself. The public has been educated to require special postgraduate training of the surgical and medical men it employs, and is willing to pay fees commensurate with such special training. In obstetrics, however, the medical school graduate, with experience in only six to twenty cases is expected to handle all the complications and operative procedures in obstetrics. The fees which the public expects to pay are in keeping with the low grade service which is given them under these conditions. . . . . It seems to me that hospital experience is as essential to the proper practice of obstetrics as it is to the practice of surgery, I do not believe that the importance of proper obstetrical training is appreciated by the profession itself, outside of the list of those who are obstetrical specialists."

It has long been the popular opinion, in medical circles, that the midwife is answerable for the large percentage of maternal deaths, especially from sepsis.

Dr. Julius Levy, of the Bureau of Child Hygiene, Newark, New Jersey, published in the February, 1923, issue of the *American Journal of Health,* a paper, in which he discusses the comparative responsibility of physicians and midwives as to maternal mortality, and gives a new angle to this tradition, presenting tables and charts setting forth his observations. He shows that in the fifteen largest cities, except only Pittsburgh, there has been a decrease in the number of cases reported by midwives, and of midwives reporting cases; there has been no decrease, rather an upward tendency, in maternal mortality; the centers having the largest percentage of midwives have the smallest percentage of maternal deaths.

Dr. A. M. Mendenhall, Indianapolis, University of Indiana Medical School, commenting on Dr. Levy's paper, writes:

"As a result or rather an intensive investigation, I find that in Indiana, as a whole, the midwife is not a very considerable problem, there being only one locality, a group of four counties near Chicago, where the midwife is much of a factor. In these counties nearly one-half of the women are delivered by midwives, with maternal and fetal deaths considerably better than the State as a whole, especially there being less puerperal sepsis."

In a personal letter Dr. Levy says: "I am not holding a brief for the midwife, but feel very strongly that no progress will be made until we, as physicians, are willing to accept the facts, and then try to develop methods that will correct conditions. . . . . If you read my article closely, you will notice that I have been very careful not to use my figures to prove that the results from available data are no worse, even after we make allowance for the fact that their cases are foreign born mothers, who present a higher proportion of multipara and a smaller proportion of risk than our American born mothers."

The inevitable conclusion to be drawn from these expressions of opinion, which typify the feelings of a large number of the thoughtful and progressive leaders of the profession, may be summarized in the comprehensive statement that much of the responsibility for the untoward results of childbirth rests within our own ranks.

The rapid decrease in the number of midwives in practice; the more drastic supervision by Departments of Health over them in the regions where they are still popular, or indispensible because of the lack of physicians; the realization that their work, among the part of the population whom they serve, shows no higher percentage of bad results than the general average of the community; these considerations eliminate the midwife as a factor to be reckoned with in the solution of the question of the continued high rate of maternal mortality.

In the towns and rural districts, and very largely in the cities, the family physician, owing to tradition, sentiment, self-interest or convenience, will care for childbirth, and the average result of his work will represent the status from which statistics will be drawn.

This work will continue to be conducted in the home. The great majority of women who are serving to perpetuate the best elements of the human race belong to the class of intelligent, self-respecting families who are dependent on salaries or weekly wages.

The disproportionately small amount of space allotted to the wards of our hospitals, the high price of the rooms and the general coincident expense makes any but charity hospital service prohibitive to this class of women. Special nurses are equally prohibitive. Obviously home confinements involve much greater risk.

The causes operating to lower the standard of the work of the general practitioner have already been suggested. They may be summarized as follows: insufficient training in our medical schools; lack of hospital postgraduate training which will enable the physician, at least, to diagnose abnormal positions; lack of appreciation of the fact that the process of labor is not surgical; lack of dependence on the obstetric specialist for diagnostic counsel rather than on the young surgeon whose obstetrical experience and preparation may be even less extensive than his own.

It is the part of those of the profession who are fitted by education, by training and by experience to take the lead in instituting a program that will remedy these conditions, and thus raise the standard of the work of the general practitioner.

Obstetrics should be made a speciality of the same rank as surgery. As many hours of the college curriculum should be given to the drilling of the medical student in the principles of the one as of the other. In a larger degree he needs a familiar knowledge of the art of obstetrics, because, regardless of his training, he will, on entering practice be called upon to attend women in labor, long before he will be called to

do operative surgery. He hesitates to call counsel in labor regardless of the condition of the patient, because of the possible reflection on his ability. Without question he can call counsel in a surgical case without affecting his professional dignity because surgery has always, with the laity, been considered the part of the specialist. Not infrequently, when counsel is called, the young practitioner yields his own judgment of the need of obstetrical assistance to the demand of the family for the only generally known specialist, and summons the aid of the surgeon.

Several years ago Dr. J. Whitridge Williams wrote a paper on the teaching of obstetrics, in which some scathing comments were made on the methods which were then employed. There has been some improvement since 1910, but even today, with the enormous shrinking in the number of medical schools, and the practical elimination of privately owned medical colleges, the demand for competent instructors in obstetrics is great, while the quality of teaching is woefully inadequate.

In no other branch of medicine is there so much chaotic difference of viewpoint as in obstetrics; nor is there elsewhere such exhibition of diversified technic as there is in the management of labor. A recent editorial in the *Journal of the American Medical Association*, commenting on this radical divergence of opinion and its disastrous consequences, sums up the subject by maintaining that in obstetrics, individualization is absolutely the key word.

Among ourselves, as specialists, individualization is possible and desirable. Individualization, however, will not solve the problem for the general practitioner. He must be satisfied with a generalization of the minimum standard of obstetric management.

Certain procedures are now recognized as a part of the routine technic of good obstetrics, that a decade ago were certainly individual, especially those relating to diagnosis and asepsis. The general practitioner, who, as a medical student, failed to acquire the fundamentals of obstetrics, or if he acquired them, fails to apply them, accepts his morbidity and mortality as inevitable because he is callous to their significance.

If every general practitioner, nay, if every man who undertakes the care of a maternity case, could be compelled to take a short postgraduate course every five years, induced to occasionally attend one of the clinics now being held annually in many of the large centers, and be urged meantime to read the standard medical journals, the result would be quickly appreciable upon the statistics of maternal morbidity and mortality. These have been so long stationary that they seem, as it were, to have become a permanent reproach to the doctors of this country.

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