The nurse in public health / by Mary Beard.

THE NURSE IN PUBLIC HEALTH

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BY

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THE NURSE
IN PUBLIC HEALTH

First Edition
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THIS BOOK IS DEDICATED

TO MY FRIEND

GRACE O'BRYAN, R. N.

PREFACE

THIS book has been written for administrators and instructors of public health nursing organizations, for lay boards of directors of these associations, for trustees of hospitals and others responsible for nursing schools, and for state and county health officers. It does not make any attempt to outline the subject of public health nursing as a whole, for that has been done most admirably by Mary S. Gardner in her book, *Public Health Nursing,* which is universally recognized as the standard book on this subject and is available in both English and French editions.

The present volume, written four years after the publication of the second (1924) edition of Miss Gardner's book, aims to supplement and enlarge upon her material at certain points and to present some current problems of public health nursing administration. It reflects the experiences and observations of the twenty-five years which I have been privileged to spend in public health nursing service, first as a visiting nurse in the ranks, then as director of a visiting nurse association, president of the National Organization for Public Health Nursing, and student of conditions in public health nursing throughout the United States, in Great Britain, and on the Continent.

The period of my service has witnessed amazing developments in preventive medicine and especially in that branch of preventive medicine known as public health nursing.

The first industrial nurse was employed by the Ver-

mont Marble Works in 1905; the National Association for the Study and Prevention of Tuberculosis was founded in this same year; and in the following year the first post-graduate course in district nursing was offered by the Instructive District Nursing Association of Boston. In 1905 the first Mental Hygiene Committee was organized in Connecticut; in 1909 the American Association for the Study and Prevention of Infant Mortality was founded; and in this same year the Metropolitan Life Insurance Company first offered home nursing to its industrial policyholders. In 1910 the course in Public Health Nursing was established at Teachers College, Columbia University; and in 1911 the first state public health nursing laws were enacted. In 1912 the Rural Nursing Service of the American Red Cross and also the Federal Children's Bureau were established. The National Organization for Public Health Nursing was established in 1912, and during my term as president of this organization in the years of the Great War, nursing committees of the National Council of Defense were appointed and the General Director of the National Organization for Public Health Nursing became official secretary to these committees, with headquarters at Washington. In 1920 the National Health Council was established.

In the United States in the year 1901 there were only fifty-eight public health nursing organizations employing 130 public health nurses. In 1928 there were more than four thousand such organizations employing over twelve thousand nurses. But still the supply of well-qualified public health nurses falls short of the demand. There are, on an average, five registered nurses available for each unfilled public health nursing

position, but often no one of the five is adequately prepared to meet the requirements of such a position. This is a serious situation which needs study. In the following chapters I shall discuss some of the more urgent problems to be solved.

I take this occasion to thank all those who have helped me to write this book: Dr. Louis I. Dublin, who gave me counsel and help in preparing the material in the chapter on "Administration of Privately Controlled Nursing Associations"; my London friends, Dr. John S. Fairbairn, Miss Rosalind Paget, and Dr. Janet Lane-Claypon, without whose help the chapter on "Maternal Care in England" could never have been written; Miss Grace Anderson, whose reports of the East Harlem Nursing and Health Demonstration were particularly valuable to me; and Dr. Ira Hiscock, whose study, "Community Health Organization," has been so freely quoted in the chapter on "Rural Nursing." To my friends Mr. and Mrs. Raymond G. Brown, and also to Miss Mary R. Boulger, of the Editorial Department of the Rockefeller Foundation, whose kindness and interest have encouraged me constantly, I am most grateful. Without my associates in the work in Boston there could have been no book; and I am especially grateful to Mrs. Ernest Amory Codman, who was president of the Instructive District Nursing Association of Boston during the first ten years of my work there. It is to her courage, her vision, and her integrity that Boston so largely owes its fine public health nursing organization of today. Our close association in those pioneer days of public health nursing is one of my happiest memories.

NEW YORK, JANUARY 15, 1929.

M. B.

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CHAPTER I

A CHANGE OF FOCUS

IT WOULD be easy to arrive at a clear understanding of the public health nurse of today if we were not in the process of adapting an old method of work to a modern program, a task made necessary by the demands and implications of a new understanding of the possibilities of the nurse's visit to the home.

We are in the habit of regarding the public health nurse as a recent recruit in the health campaign. Her rapid development in the past ten years has made us think of her in this way; but nothing could be more inaccurate, for the historic beginning of her activities can be traced far back, almost to the earliest days of nursing as we know nursing today. In many localities of the United States, Canada, England, Ireland, and Scotland district nurses have been stationed constantly for the past thirty years. The Victorian Order of Nurses in Canada and many voluntary visiting nurse societies in our own country have been responsible for the continuous work of these nurses over what is now a long period of time. The mortality due to tuberculosis,

to ignorance of the proper care of babies, to bad maternal care, has produced at various moments in the history of public health development in this country groups of nurses who have been trained, as best served the occasion, to undertake the specialized type of health teaching demanded by the particular movement on foot.

The district nurse of England and of the United States was the forerunner of the school nurse, and of the baby-welfare, maternity, and preschool nurse. Sometimes she has been known as a district nurse, sometimes as a health visitor, sometimes as a visiting nurse; but today she is universally called a public health nurse.

It is nearly twenty years since recognition of the value of school nursing caused the city of New York to add eight hundred school nurses to its payroll at one time. The attitude of those most closely concerned with social work in New York institutions at that time was expressed by a remark made by one of them, "What can we do? The city has unloaded eight hundred nurses upon us." Nurses had then no knowledge of social work nor had they any specialized knowledge of the laws of sanitation or hygiene, or even of what constitutes a normal, healthy child. And yet nurses have struggled into that knowledge, or at least into some part of the education needed to do school nursing. Today no one doubts the value of the school nurse.

A New Conception of the Public Health Nurse

In the earlier days of visiting nursing, emphasis was laid on bedside care: the ideal of the nurse was to leave patient and bedroom as immaculate as hospital régime

demanded; it was not considered important to teach the members of the family to do all they could for the patient—to wash her face and comb her hair, for example—before the arrival of the nurse, nor was much attention given to the instruction of the family in matters of general hygiene.

As preventive medicine developed, demands arose for teachers who could spread among fathers, mothers, teachers, schoolchildren, and employers of labor the scientific knowledge acquired in the laboratory; in short, there was created a demand for the public health nurse. In outlying districts where there could be but one nurse for a widely scattered population, it became the common practice for this nurse to carry on the health teaching suggested from time to time by the committee under which she worked. Often she herself was the first to see the new need and to stir her committee to see it.

Today the two ideals of public health nursing are these: the bedside care of a sick person under the direction of his own doctor, and the instruction of the patient's family in home nursing and the laws of health, in accordance with the teachings of the modern health officer.[1] Although the nursing of the sick in their own homes is the first business of many modern public health nursing associations, this nursing is not like the nursing of hospital patients or private patients. The function of the public health nurse in relation to the sick is to teach home nursing by demonstrating to the members of the family how they may carry on during the long hours

[1] It will be understood by any of the experienced public health nurses of ten years ago, of which the writer is one, that the contrasts drawn between former times and the present refer not to individual work, but to the defined and recognized plans of work for the two periods.

between her visits. Her visit is of consequence, for its character and purpose may make all the difference between success and failure in the community health program. The visit, if it is successful, will, through health class, public school, conference, or clinic, correlate the home with the community facilities for health.

When we recall how many persons come daily under the care of a public health nursing association, we appreciate that it can be only through the individual good work of every nurse during every visit that we can hope for adequate results.

Public health nursing has developed further in the United States than elsewhere, and even though the development is very unequal and there are great gaps in the organized program in every one of the forty-eight states, the trend of the movement and its adaptation to a changing health program can probably be followed better in the United States than in any other country.

Miss Mary S. Gardner, a student of public health nursing better fitted, perhaps, than anyone else to evaluate its program, has pointed out certain changes of emphasis observed in recent years. Speaking at the International Council of Nurses, meeting in Helsingfors (July, 1925), on the shifting emphasis, she said that the "patient," or the individual under the care of the public health nurse, has come to be regarded much as a student is regarded by a good teacher.

Disease prevention, she points out, has grown to be a community interest in many localities. Since we have learned that a large proportion of our children are infected with tuberculosis bacilli, public health nurses are concentrating upon the health of all children. They are recognizing the danger in bad early mental habits and

are helping parents and children to correct them. They are seeking to stimulate the interest of the schoolchild in his own ability to become physically fit; and the child has become an eager ally in the school nurse's program for his health. He has learned to wish to weigh as much as he ought and to have healthy teeth and good posture, vision, and hearing. Not only the schoolchild, but the young mother or father, becomes a "student," and health is taught and learned through this cooperation.[2]

And as the public health nurse has found her own unique place in local health programs and has learned to fill it, she has come to be sought as a consultant and counselor wherever comprehensive plans for the promotion of a health program are made.

A Nurse the Logical Public Health Visitor

All experience seems to indicate that the basic training of the nurse, altered though we all know that training ought to be in many essential ways, makes the best preparation for the public health visitor. Furthermore, the health visitor must often work under the direction of the local doctors of the district to which she is assigned, and the fact that doctors like the help of nurses is an added reason why the health visitor should be a nurse. In the best of our departments of health, whether state or city, there is close cooperation with the practicing doctors. In the case of the public health nursing program such cooperation is especially essential, for the private doctors are invaluable allies in securing

[2] Mary S. Gardner. "Changing Emphasis in Public Health Nursing" in *The I. C. N.* (official organ of the International Council of Nurses) (Jan., 1926) pp. 39-48.

the interest of their patients in the health teaching. The nurse must be educated to understand her responsibility to the local doctor, to the health officer, and to the community. When this has been accomplished she becomes effective as a health teacher and does not encounter that antagonism almost inevitable when a visitor does not fit naturally into the existing neighborhood organization. The nurse already has her place there.

In England at the time of the World War, there was a new type of worker, known as a health visitor. Her functions were those performed by public health nurses in the United States; but in England an attempt was made to educate her for health visiting without having her pass through all the preliminary training required of English nurses. With the extended health program of 1918 the number of such health visitors was greatly increased. In 1925, however, the Ministry of Health amended the ruling relating to the appointment of health visitors, so that preference is now given to the applicant who has had a nurse's training. At the time this amended ruling was made public the Ministry of Health stated its intention of eventually making the nurse's training obligatory for health visitors.

Aims of the Public Health Nurse's Visit

It has been said of the public health center that "the real work must be done by the nurses in the homes." The development of the next few years in community health programs is dependent upon a full understanding of the object and character of the visit of the public health nurse.

Present-day courses in public health nursing seek to

prepare students to think clearly about the many important community problems which present themselves so constantly in daily visiting. The family is the center of interest to a public health nurse, and family health is the end she hopes to attain. Although sickness often opens the door to her and the care of the sick may still be her first concern, her mind during her visit is focused upon the means at her disposal for helping the family to become well and keep well. She is responsible for the health of each individual member of the family and will therefore, where it is possible, time her visits so that she may see each one before her connection with the family comes to an end. Every effort is made by the public health nursing associations to emphasize the family as the unit of interest to the nurse on her visits. Record cards are printed with space for notes on the health of each child and adult in the home.

In most of the associations certain visits are made for the purpose of teaching only, but even in these visits the emphasis is placed on the practical nature of the teaching. The nurse's coat and hat are taken off, and the social character of the visit is eliminated as far as possible even when most of the time is to be spent in talking. When sickness is present the public health nurse usually remains about an hour in the home. During this time she not only cares for the patient but teaches some member of the family to give the necessary nursing care in her absence.

In order that her visit may be of the greatest value to the patient, the family, and the community, she must teach the members of the family not only how to give the patient nursing care but also how to avoid future ill-health as far as is possible and how to overcome

physical defects already existing. In the communicable diseases of childhood it is essential that parents be taught how to care for the patient and how to protect other members of the family; they must be led to understand that an early diagnosis through laboratory tests is of utmost importance, that antitoxin given to a child with diphtheria when the disease first develops may save his life, and that it is dangerous to permit well children to associate with sick children.

Difficult though it often is to convince the people of these facts, mothers anxious over their sick children will usually be found responsive to the efforts of the nurse to help them, and the influence of the woman who comes into the home, rolls up her sleeves, and works hard for an hour giving bedside care to a patient, is likely to be considerable. Without doubt her instructions to the mother, as well as her own actual service to the children sick with measles and whooping cough, greatly reduce the number of subsequent cases of pneumonia, bad conditions of the eye or ear, and many other preventable sequelæ.

The teaching of nursing procedures requires skillful and repeated demonstrations of the tasks to be done; and the visiting nurse of today may therefore spend as busy an hour of actual work with her hands as the nurse of the past used to do. That all her teaching must be skillfully and tactfully done we can well appreciate when we consider the many races represented by the people under her care, their various standards of living, the unsatisfactory conditions with regard to food, cleanliness, and space under which they live, and the possibility of cross-infection.

It is sometimes argued that an hour's visit, given to demonstration of nursing procedures requiring hard physical work on the part of the nurse, cannot possibly be made to contain other teaching that will be of value to a family—instruction, for instance, regarding the hygiene of pregnancy, the care of young babies, the importance of proper food, the laws controlling communicable diseases (including tuberculosis and the venereal diseases), the necessity of having physical defects corrected early or of examination for the child whose temperament or surroundings are producing bad mental habits. It is contended that these things cannot be taught during the visit of the public health nurse, and yet it is lack of elementary knowledge on these points that is found to be at the root of most of the poor health the nurses will encounter.

By further consideration of the visit we shall see that both kinds of teaching are not only practical but inevitable. There is no dividing line between sickness and health. If there were perhaps it would not have been the nurse who would have become the successful agent of preventive medicine. Beginning at the very onset of life, the normal physiological process of birth involves a ten-day interval at least during which the mother requires bedside nursing. She must stay in bed, therefore in one sense she is a patient; and her future health may depend upon good care, even though her condition is quite normal. The growth of prenatal nursing has been far more rapid because this is so. Since the expectant mother appreciates fully the comfort and peace of mind arising from the knowledge that a visiting nurse will come to see her every day while she

is in bed, she is much more tolerant of frequent prenatal nursing visits, when teaching is the nurse's chief function. It has also been found that the mother is much more receptive to teaching about the proper care of her child when there is continuity in the whole cycle of instruction from the early days of pregnancy to the time when the child is old enough to go to school. In this work, too, the teaching visits are seldom devoted entirely to verbal instruction, for such nursing procedures as the taking of blood pressure or the analyzing of a specimen of urine have become part of a prenatal visit, and the actual demonstration of making a milk formula or preparing early foods is part of a baby visit.

In England one of the outgrowths of the needs of the expectant mother has been the establishment of the nurse-midwife (see p. 122), who in many rural places has, under the Midwives Act, assumed the conduct of normal delivery also. So successful has she been that under her régime the irreducible minimum of maternal mortality seems, under certain conditions, to have been reached.

In the cases handled by the nurses of Queen Victoria's Jubilee Institute (see p. 119) in 1923 the maternal mortality was only 1 per 1,000 births, while that for the whole of England and Wales was 3.8 per 1,000 births. In considering the former figure we must bear in mind that practically all that can be done to save life through prenatal care had been done for those mothers. In one sense they were picked cases, but in another they were but one more evidence that the nurse in public health is able to bring to her charges those simple but all-

important facilities for health which make them picked cases, with a better expectation of life than the average person

Public Health Nursing Administration

There has been until recently little attempt at standardization of technic in teaching people how to keep well,[3] and there has been a great deal of uncertainty as to what ought to be the content of a public health nurse's visit; yet the nurse cannot do effective health teaching in the home unless she has a definite working program which she has been fitted to carry out and unless the conditions of organization under which she works are conducive to teaching.

The value of a public health nurse's visit to a home, or of her contact with a neighbor who pays her a visit in the nursing center, may be graded by measuring her success in relation to the following five points:

1. Was her public health nursing technic good?
2. Did she observe and grasp all opportunities to teach health in the family?
3. Did she try to discover the underlying social causes of the health conditions observed?
4. Was her personal relation to the family good?
5. Was she alert to relate her visit to the policy of the agency with which she was connected?

If she looks upon the family, not one individual member of it, as the unit on which her visit must focus, it

[3] Report of The Committee to Study Visiting Nursing, instituted by the National Organization for Public Health Nursing at the request of the Metropolitan Life Insurance Company, New York, 1924.

is probable that the visit will be effective. If the training of the nurse with regard to the teaching of her patients and of the family has been adequate, a nursing visit means not only immediate care, or demonstrations and instructions showing how care should be given while the nurse is away, but also the teaching of health habits for the whole family. We may grade the value of her visit as to personal contacts according to the spirit of the visit, sympathy, courtesy, adaptability to individuals and situations. Public health nursing technic has been developed for nearly all health services, so that it is now possible to grade this professional aspect of a visit. Point 3 deals with the nurse's ability to determine underlying causes of illness or low grade of family health and the best way to call upon community resources to combat them. Finally, her visit will be effective to community health in so far as she is familiar with and loyal to the policies of the organization of which she is a part, for each community organization develops, in so far as is possible, ethical contacts with all other local health or social agencies.

During the past four years a flood of light has been thrown upon the many uncertain points of public health nursing administration by an exhaustive study which is going forward in the city of New York under the auspices of the East Harlem Nursing and Health Demonstration,[4] and partly as a result of this study rapid

[4] The East Harlem Nursing and Health Demonstration was organized in December, 1922. The area covered by its activities extends from 109th to 119th Street, and from First to Third Avenue. The agencies cooperating in the experiment are the American National Red Cross, the Henry Street Visiting Nurse Service, the Maternity Center Association, and the Association for Improving the Condition of the Poor.

progress is being made in developing a technic for public health teaching.[5]

The Henry Street Visiting Nurse Service, the Maternity Center Association, and the Association for Improving the Condition of the Poor pooled their facilities in the Demonstration so that bedside care, maternity and infant care, baby welfare work, and the care of the preschool child were included in the functions of the demonstration staff. The sum of $1.50 per capita was allowed for the work. The activities of the demonstration were intended to supplement the health work of the municipality.

There are those who are convinced that the territory covered by a given public health nursing organization should be divided into small districts, in each of which a single nurse would care for all types of work undertaken by the organization. This has been called generalized nursing. On the other hand, there are those who think that each nurse on the staff of the organization should be responsible for a special kind of case and that all cases of a single type within an entire territory should be delegated to the nurse in charge of that type. This has been called specialized nursing.

The study of the East Harlem Nursing and Health Demonstration included an investigation, covering a one-year period, of the relative merits of these two procedures. In the area in which generalized nursing was carried out there was greater overcrowding and the percentage of illiteracy was 20, while in the specialized area it was 9. The services offered fell into two general groupings: (1) home visits and (2) visits of mothers,

[5] *A Comparative Study of Generalized and Specialized Nursing and Health Services,* by the East Harlem Nursing and Health Demonstration (New York, October, 1926).

fathers, and children to the center to attend clinics, classes, and clubs. The two types of administration were reported upon as follows:

I. There was no demonstrable difference in the quality of the separate nursing services rendered under the generalized and specialized types of administration.

II. There was a marked difference in the volume of nursing services which were rendered in approximately the same amount of field time:

1. In the generalized area the workers visited 27 per cent more families, gave sickness care and health supervision to 46 per cent more individuals, and made 40 per cent more visits than did the workers of the specialized area.
2. In addition to supervising a large number of families and individuals, the generalized workers averaged approximately the same number of visits per case as did the specialized workers.
3. The response to home visits, as indicated by the attendance at clinics, classes, and clubs,[6] was greater from the generalized area notwithstanding the lower educational and social status of the people in this area.

III. The cost per visit of the specialized worker was increased over that of the generalized worker because fewer and longer visits were made by her and more time was spent on general office activities chargeable to the cost of the home visit. The increased cost per visit raised the average cost per case in the specialized area to $6.93, while in the generalized area this cost was $4.69.

IV. There were indications that the generalized nursing services tend to meet community needs more completely than do the specialized services:

1. Under the specialized plan duplication of visits was avoided, with only partial success, by daily vigilance on the part of the workers.
2. A general plan for the family welfare could be formulated only by several special service representatives, and fre-

[6] This refers to the total attendance at clinics, classes, and clubs.

quent group conferences were necessary in order to place the responsibility for the execution of the plan.

3. When the health work was further complicated by social problems that involved extended cooperation with social case workers, specialization became impossible and the responsibility for the health work in these families was finally given to one worker.

V. The morbidity service did not absorb an undue proportion of the time of the generalized workers, although the percentage of time given to this service was higher in the generalized area.

VI. The administration of nursing services under the generalized plan simplifies many details of office management, supervision, and record work. The training of the new worker requires additional time for each service included in the general program, but this results in a comprehensive vision of the health field which makes for greater efficiency in all services.[7]

These are interesting facts which will greatly influence the coordination of public and private programs in the future. The East Harlem Demonstration has taken a strong hold on the people of the neighborhood. Recently, postal cards sent to thirty-five mothers asking them to bring their babies for physical examination produced every one of the thirty-five.

For the benefit of readers unfamiliar with the work of this Demonstration a few words may be added to show just what it means to a neighborhood to have a public health nursing service of this sort. Not long ago I visited the Demonstration Center while a baby conference was in progress. The atmosphere of the place was thoroughly homelike and uninstitutional. In one of the pleasant cheerful rooms a doctor was examining the babies who had been brought by their

[7] *A Comparative Study of Generalized and Specialized Nursing and Health Services,* pp. 32, 33.

mothers by appointment. There was no large group of mothers waiting long hours for attention. In another room nurses, nutrition workers, and mothers were all occupied in teaching or learning, or both. We sat down near the supervisor of nutrition work, who is responsible not only for her own nutrition workers but for the teaching of nutrition by the nurses. A mother with a baby on her lap was being shown the foods to give her family. This was a practical lesson and interesting to the mother. The nutrition worker was sure of the few points she wanted to make and equally sure of the method she meant to use in teaching the particular mother who was her pupil. The mothers of the district have been tested and classified as to their mental capabilities, so that doctors, nurses, and nutrition workers know whether a ten year old or a twenty-five year old mind is to be taught.

It is now four years since the families in this area came under the supervision of the Demonstration Center. Certain children whose mothers were under care during the prenatal period have nearly reached school age. Some of them are children who had been exposed to tuberculosis. The records of these children have been carefully kept; the children themselves are available for study and, so far as modern knowledge of preventive medicine and hygiene makes possible, their health has been protected consistently all their lives. They have been (1) immunized against diphtheria, smallpox, and scarlet fever; (2) corrected as to defects, such as adenoids and diseased tonsils, decayed teeth, poor posture, underweight; (3) treated for congenital syphilis when necessary; (4) cared for in acute illness and their homes protected when the mother was ill, so that they have not

been neglected at such times; (5) guided by experts in behavior problems.

Such "fit" children as these seldom enter our public schools. It is the public health nurse alone, of the many essential community health workers, who, as the Commonwealth Fund Report states, can bring together, and into the child's everyday life, all that he needs to become "fit," granted, of course, that the community provides these health facilities.[8] The public health nurse, alone of all the community workers, goes into the homes and teaches health there. Hers is the task of correlating all the advice, treatment, and teaching of the many health services, and to her the mother turns for help in learning how to nurse her sick child. The public health nurse must know pediatrics, obstetrics, and medicine from a nurse's point of view, because, although the modern health officer may think that he values her for her success in preventing and controlling communicable diseases, she is not successful in this unless she is able to bring about healthful conditions of living in the home; for children having diseased tonsils, adenoids, or defective teeth, for example, will contract communicable diseases sooner than children not so handicapped. The task is an intimate and delicate one requiring careful education of the public health nurse and also careful organization of her time.

Staff Specialists

The presence of specialist nurses on the staff of the public health nursing association to help the general staff

[8] The Commonwealth Fund Child Health Program, Bulletin No. 1 (February, 1927).

has been found to be essential, for the present at least, for advisory services, consultation, and the follow-up work required in health teaching. But the various specialist supervisors should have as their objective the maintenance of a high standard of work among the staff nurses, not the building up of specialties on their own account.

Recently the value of occupational therapy in the work of public health nurses has received a good deal of attention. It must be taught, of course, by those especially trained to teach it, but the closest connection must be kept between these workers and the public health nurses who know the families so well. There is at present no standard for the administration of occupational therapy in public health nursing associations. In some instances occupation therapists have been added to the corps of association workers, and in some an organization has been built up for buying materials and selling completed products of the patients' work. On the whole the better arrangement would seem to be the establishment of a central bureau cooperating with community agencies.

With regard to the problem of the proper nutrition of families there is also some uncertainty as to administrative procedure: no definite standard has been developed for nutrition workers, and their relation to public health nursing associations has not been fully determined. Much of the time of dietitians or nutrition workers connected with the associations ought to be devoted to teaching and directing public health nurses. Women who have been taught during their public health nursing courses the relation of nutrition to health and and the importance of taking family or racial traditions

into account in nutrition work, ought to become valuable nutrition teachers if they are given enthusiastic and dependable direction by the specialist.

Public health nurses need more knowledge of mental hygiene. Almost every day some family presents a need which perhaps only the nurse could ever observe. Good work can be done by the nurses in preventing disastrous results from neglect of mental symptoms when, through a specialist supervisor in mental hygiene, closer relations are established between public health nurses and local psychiatric clinics.

Educative supervision becomes a feature in public health nursing administration, and wisely and inevitably so, since 71 per cent of all agencies employing public health nurses in the United States have only one nurse.[9]

[9] "The Census of Public Health Nursing in the United States." Prepared by the National Organization for Public Health Nursing, 1924. (Reprinted from the May, 1926, number of *The Public Health Nurse,* p. 250, Table 1.)

CHAPTER II

THE RURAL COMMUNITY

IN THE United States the National Organization for Public Health Nursing has done much to standardize and stabilize rural nursing. The American National Red Cross has undertaken the promotion of this work as a conspicuous part of its program, and there are few communities which have not been stimulated through its efforts. Speaking generally, however, the expansion of a public health nursing program in rural counties cannot be rapid, and additions to the ranks of public health nurses cannot keep pace with the demand.

Division of Functions between Public and Private Agencies in Rural Nursing

In the field of rural nursing no hard and fast line of division can be drawn between the functions of governmental and private agencies. Activities which cannot be undertaken by a governmental organization in one locality or at one period of time often can, with changing conditions, be taken over by such an agency. Sometimes the state department of health takes advantage of public sentiment and stimulates the activities of a group of private citizens, encouraging it to assume responsibility for some health function which at that moment cannot expediently be undertaken by the state. As an illustration of this, we have seen certain health activities

which had been initiated by a parent-teachers association taken over by a department of health. Prenatal care has often been developed by a private visiting nurse association and later incorporated in the program of the municipal health department. In this way the demarcation between the functions of public and private agencies shifts and varies and sometimes wholly disappears.

Voluntary agencies can, and should, keep ahead of official health practice in each locality, advancing steadily to newer fields as each of their demonstrations proves successful and the constituted authorities are ready to take full responsibility for the activity.[1] I have selected for discussion, in illustration of this point, two public health enterprises in the United States toward which grants are given from private funds: one of these is the county health unit program, in which The Rockefeller Foundation is interested; the other the Child Health Demonstrations of the Commonwealth Fund in North Dakota. I shall also describe briefly in this connection two other enterprises, namely, a recent development of health work under private auspices in the United States, known as the Frontier Nursing Service, and the public health nursing organization of the county of East Sussex in England, which coordinates in a common program all the privately controlled and all the official public health nursing in the county.

The County Health Unit in the United States

A full account of the county health unit in the United States, written by Dr. John A. Ferrell, appeared in the

[1] The Rockefeller Foundation Annual Report, 1923 (New York, 1924), pp. 81, 82.

Public Health Nurse for June, 1926. This article shows that before the year 1910 only one county in the United States laid claim to a full-time health organization. By the end of 1925 two hundred ninety-nine such units had been organized. They originated in states where the county is the administrative unit, and through their agency it was hoped to give adequate health service in villages and rural communities, with the home and the public school as the working centers.

Often, although not always, the personnel of the county health unit consists of a full-time health officer, a full-time sanitary inspector, a public health nurse, and a secretary or clerk. The unit is frequently supported jointly by the state board of health and the county commissioners of health, occasionally also by the county school board. These agencies sometimes cooperate in the selection of the health officer. Voluntary public health agencies often affiliate with the unit and even occasionally advance funds pending the next tax levy. If the total cost of maintaining the unit is between $7,500 and $10,000 a year, the State Department of Health frequently contributes $2,500 and the county $2,500. The maximum yearly amount contributed by the Rockefeller Foundation to any single county unit is $2,500. A study of eighty-eight county health units which operated throughout the year 1925 in five southern states, serving a population of 3,870,311, showed that $.324 per capita was spent in their work, representing slightly less than a half mill tax. Of the total county health funds, $2,500 is required for the traveling expenses and salary of the public health nurse or the sanitary inspector.

With few exceptions, where competent personnel has been employed, county health units once started have not been discontinued. It is important, says Dr. Ferrell, that suitable field training and aptitude for the work both in the case of the public health officer and the public health nurse be insisted upon, for if the taxpayers do not recognize the health service as a good investment they will not continue to support it. Dr. Ferrell points out that it is not to be expected that a great deal can be shown in lowered death rates as a result of a movement that has been fully under way for not more than ten years. Eighty per cent of the 299 county organizations existing at the close of 1925 were established during the six years preceding that time. It is already possible, however, to compare death rates for typhoid fever, diphtheria, diarrhea, and enteritis in babies under one year of age of a group of six or more counties in several states in which full-time health units have operated for a number of years, with a corresponding population group where full-time service has not been in operation; and such a comparison shows the trend of death rates distinctly favorable to the counties with full-time service.

Commonwealth Fund Child Health Demonstrations

In the annual report of the Commonwealth Fund for 1926 will be found a description of its child health demonstrations.[2] Started in 1923 at Fargo, North Dakota, these activities comprise two rural counties and two

[2] One questions whether the word "demonstration" conveys the purpose of the work in these centers as well as the word "study" would do.

small cities. Their purpose is "to encourage the greatest possible local demand for a well-rounded health program coupled with a real sense of proprietorship in it so that the community may better bridge the wide gap between knowledge and practice in child health." The program is directed jointly by the National Committee of the Commonwealth Fund and the community in which the demonstration is located. It is financed partly by funds from the community, but largely by the National Committee. The program calls for (1) assistance by the national body in such enterprises as are mutually agreed upon as giving promise of being worth while and of being accepted by the community, (2) advisory service as required, and (3) increasing local support with decreasing gifts from outside.[3] A local advisory committee is formed in each demonstration center. These committees guide the work and will be the strongest influence in insuring permanent local support. It is hoped that they may help to show how far a local committee may take part in the actual promotion and development of local health services.

In a report of February, 1927,[4] the following description is found of the plan on which the demonstration programs have been organized:

> While recognizing the limitations imposed by local problems and local readiness to undertake certain phases of health protection, the Committee has from the beginning believed strongly

[3] From the Commonwealth Fund Annual Report (New York, 1926), p. 14 *et seq.*

[4] Commonwealth Fund Demonstration Committee, Bulletin No. 1 (February, 1927)—"The Child Health Demonstrations, Programs and Policies." (Reprinted from the Commonwealth Fund Annual Report, 1926, pp. 14-29.)

in combining measures which safeguard the individual from the dangers of infection, with those which build bodily vigor and resistance and give the individual knowledge and interest in ways of health which will do most to insure his enjoyment of good health and his support of public services and of necessary appropriations. This is in direct disagreement with the view that a sacred right of priority is inherent in those measures directed towards the suppression of acute communicable diseases, and that all other activities such as regular medical examinations, correction of defects, and the health education of school children should be postponed until activities to meet epidemic conditions are thoroughly established.

In one of the small cities in which a demonstration is being conducted the per capita expenditure from local funds for this work has risen from $.28 to $.97 within a four-year period, and in another city it has risen from $.71 to $1.41. In one rural area it has increased from $.10 to $.33, and in another from $.14 to $.30. The adequacy of local health work, during successive years, in the demonstration cities has been determined by the use of the Appraisal Form for City Health Work,[5] a measuring device recently prepared by city health officers and other health workers, meeting at the request of the American Public Health Association. Fargo, North Dakota, shows, by this measure, a marked improvement in almost all items of the appraisal.[6]

[5] The appraisal form of the American Public Health Association scores on eight points, with four subheadings under "health of the child." These are: vital statistics, communicable disease control, venereal disease control, tuberculosis control, health of the child (1. prenatal, 2. infant, 3. preschool, 4. school), sanitation, laboratory, popular health instruction. "The Appraisal Form for City Health Work," American Public Health Association (New York City, March, 1925), 37 pp.

[6] "A Survey of Public Health Work in Fargo, N. D.," by W. F. Maeher. Commonwealth Fund Child Health Program, Bulletin No. 5.

The Frontier Nursing Service

In the mountains of Kentucky, where the only means of communication is very slow progress on foot or horseback along the "cricks," may be found a most interesting illustration of a private organization attempting to demonstrate how the health needs of the people may be met. Our maternal mortality in the United States is twice as high as that of England. The mothers of rural America are fearfully neglected; and while it is true that the maternal death rate is high in our large cities in spite of good health facilities, yet it is important that some special provision be made for mothers in the rural communities. As an experiment in meeting this need a committee of interested private citizens has been organized to raise money and conduct maternity nursing centers with a complete generalized public health nursing service. They have chosen Leslie County, Kentucky, for their first demonstration.

The State Department of Health endorses the work of the committee, giving the public health nurses authority as licensed midwives to conduct normal confinements as well as to perform certain other services such as immunization against communicable diseases. Owing to geographical difficulties the per capita cost of this work is only slightly under $2.50. The committee proposes next to undertake work in a rural county in another state where such difficulties will be less. It hopes eventually to extend its work to many rural communities of the United States. This is service of a type which no official health organization is as yet prepared to undertake.

The story told by the public health nurses engaged in the work is the vitally interesting human story of the pioneer. In just such a way was the Queen Victoria's Jubilee Institute for nurses established in England many years ago. That agency still functions as a private organization throughout England and Wales, but in some localities it has demonstrated how completely such a private health agency may be coordinated with the official health program.

Public Health Nursing Organization in the County of East Sussex, England

The county of East Sussex, with the soft green slopes of the English downs stretching upwards from the sea, is one of the most beautiful sections of England. Here is to be found an organization of public health nursing which, for its locality, seems to provide better for the needs of the people, to waste less time and money, and to cause less friction that any other plan of which I know. In this county the good will of those concerned in health work has produced a complete coordination of all private and all official public health nursing activities. Through this cooperation the greatest possible efficiency has been produced at the lowest cost. There is no longer any separation between the various groups of public health nurses. Together they work at one program, under one direction, with one standard of preparation, salary, and promotion. Dr. Foulerton, the medical officer of health for Sussex, describes the joint nursing scheme as follows:[7]

[7] Annual Report of the County Medical Officer of Health for Sussex, for the year ended December 31, 1923.

The scheme for coordinating the County Council's public health nursing work with the privately controlled nursing work by means of a close cooperation with the East Sussex Nursing Federation, has, since its inception, worked most satisfactorily. The arrangements, generally, are these: The appointment of district superintendents rests with a joint committee, which consists of two members of each of the three executive committees of the County Council (the committees on Public Health and Housing, Maternity and Child Welfare, and Education), which are specially concerned with nursing work, and four representatives of the East Sussex Nursing Federation (privately controlled). The five district superintendents work under the general supervision of the county nursing superintendent, who is also appointed inspector of midwives under the Maternity and Child Welfare Committee. Each district superintendent lives in her own area and is responsible for the supervision of the district nurses (privately controlled) in that area, and for various other work as indicated below. This work may be detailed most conveniently in relation to the work of the several committees concerned.

The five district nursing superintendents carried out during the year the following work for the three committees of the County Council which are directly concerned, together with the East Sussex County Nursing Federation, in the joint scheme:

I. *Maternity and Child Welfare Committee*

(1) Infant visiting: The district superintendents are responsible for routine infant visiting in the relatively small number of parishes in which a district nurse is not available. The total number of visits paid to infants and young children during the year were as follows:

a. To infants under the age of twelve months: 616 visits.

b. To infants and young children between the ages of one and five years: 866 visits.

(2) The district superintendents are also responsible for the supervision of the infant visiting work of the district nurses.

(3) Attendance at maternity and child welfare centers: There are thirty-one such centers established under the supervision of the Maternity and Child Welfare Committee, and these were visited on 174 occasions. Talks on the management of infants and young children were given at 157 of these visits; the seventeen other visits were made for the purpose of inspection, etc.

(4) Supervision of midwives: About 184 certified midwives were in practice within the county area during the year; and 410 visits of inspection were made. In addition to these routine visits for inspection, etc., forty-eight special visits were made in connection with cases of puerperal infection, ophthalmia neonatorum, etc.

II. *Education Committee (Medical Inspection Subcommittee)*

(1) Attendance at routine medical inspections of school children: on occasions of emergency, when the services of a district nurse have not been available, the district superintendents have attended, for the purpose of assisting, at eleven routine medical inspections and at thirty-three dental clinics.

(2) Routine head inspections: 181 visits to schools for the purpose of inspecting the children's heads have been paid by the district superintendents; altogether eighty-one schools were visited, and 13,620 examinations were made.

(3) Arranging for attendance of children at hospital treatment centers: the district superintendents arranged for the attendance at hospitals of 244 children requiring operations for enlarged tonsils and adenoids and for minor ailments, or for refraction.

(4) Swabbing throats, in connection with outbreaks of diphtheria or suspected diphtheria: during the year ninety-four children were visited at their homes for the purpose of taking "swabs" from

the nose and throat; altogether 132 "swabs" were taken and submitted to bacteriological examination.

III. *Public Health and Housing Committee (concerned with tuberculosis)*

The work of the district superintendents for the Public Health and Housing Committee is mainly in connection with tuberculosis. Four of the five superintendents act as dispensary nurses at the four county dispensaries for tuberculosis and have attended at 250 sessions; 558 home visits have been paid to persons with tuberculosis. The superintendents also arrange as to the setting up of out-door shelters loaned by the Public Health and Housing Committee to tuberculosis patients.

In addition to the routine work detailed above, the district superintendents have given much help in other directions by arranging the admission into hospitals of women and young children, under the Maternity and Child Welfare Committee's scheme, and by making inquiry in connection with various branches of the county public health work. Two of the district superintendents have been appointed petitioning officers under the Mental Deficiency Act, 1923, for the purpose of presenting petitions in cases for which the County Committee for the Care of the Mentally Defective are responsible.

As stated previously the working of the joint nursing scheme has been entirely satisfactory, and further improvement in several directions has been noticeable during the year, which has raised the efficiency of the district nurses very considerably. The district superintendent is able to keep in close personal touch with her own group of nurses, and the district nurses themselves appreciate very highly the support and advice which they can get through her. All the district superintendents' work has been carried out very smoothly, and without the least friction with the local nursing

associations. The manner in which the district superintendents have carried out their sometimes rather difficult, and always very arduous, duties is beyond all praise.

Experience of the first two years has shown that the allocation of the cost of the district superintendents (as to two-fifths to the Maternity and Child Welfare Committee, as to two-fifths to the Education Committee, and as to one-fifth to the Public Health and Housing Committee) represents a fair apportionment, having regard to the amount of work required by the several committees.

IV. *District Nursing Arrangements*

Altogether eighty-three district associations, employing 111 nurses, receive nursing grants from the County Council.[8] Of these associations eighty are affiliated with the East Sussex County Nursing Federation, and three are "unattached." Out of a total of eighty-five nursing associations working in the county area there are only two which have not been able to cooperate with the county authority. The grant allowed by the County Council is based upon the salary paid to their nurse by the district association. Speaking generally, in the case of a whole-time "midwife" (i.e., a nurse who does not do any general nursing), the grant is equal to the salary paid; in the case of a "maternity nurse" (i.e., a nurse who is occupied in both midwifery work and general nursing), the grant amounts to one-half of the salary paid. In either case, all fees received by the association in respect of either midwifery or maternity nursing are deducted from the grant allowed for the year. In addition to the "midwifery and health visiting" grant, a small annual allowance is made in respect of cost of uniform and upkeep of bicycle.

[8] The district nursing associations receive grants in respect of the midwifery, maternity nursing, and public health visiting work of 95 of these nurses.

Dr. Foulerton adds elsewhere:

The practical value and efficiency of the work carried out under the County Nursing Federation are matters which, fortunately, can be submitted to the test of statistics. The maternal mortality rate shows the number of deaths occurring amongst mothers per 1,000 children born alive during the year. Taking the maternal mortality figure for the whole country as 4, the maternal mortality in East Sussex was equivalent to a rate of 2.9 deaths per 1,000 births in 1923, and 3.31 deaths in 1924. Taking the rates for the two years this means roughly that, as compared with mortality for the whole country, one mother was saved for every 1,000 children born in each year. The influence of the trained nursing service which the County Nursing Federation has maintained in East Sussex is shown by the fact that out of 3,092 births registered in the area for which the Federation is responsible (i.e., the Administrative County of East Sussex less the Borough of Hove) 2,198 cases were attended by district nurses, acting in 1,661 cases as midwives, i.e., without the service of a medical practitioner, and in the remaining 537 cases as maternity nurses under a medical practitioner.

Dr. Foulerton's estimate of the cost of the maternity and child welfare scheme for the year ending March 31, 1926, was £9,111. Of this the contribution from the county was £4,448, and the government grant amounted to the same sum.

The Four Projects in Brief

A summing up of the stated purpose of each of the four projects discussed in the foregoing pages may be of value here:

The purpose of the cooperative county health unit is to inaugurate a practical health program and operate it at a cost which the county can assume when the value

of the work has been demonstrated. The sponsors of this movement believe that to show a course practical enough to be followed is not only worth while for the chosen county, but has a distinct value in suggesting to other counties that they too must have a health unit. To "begin small," so that the taxpayer will be persuaded that he can carry the cost, seems to the state health officers and others interested to be a more solid educational venture than to begin with a program which could not be financed by the taxpayer no matter how great his interest might become.

The Commonwealth Fund child health demonstrations are centers where there is intensive study of the relation between practice and knowledge of child health habits in rural communities and small cities. These centers do not demonstrate in the sense of showing a community a practicable program which could be carried on, intact, by the local taxpayer. They contribute, through intensive study in given localities, valuable data on which future health programs will be based.

The Frontier Nursing Service is far ahead of official health practice in that it is attempting to provide a complete service for mother and baby in remote rural communities before, during, and after childbirth. The cost is quite out of the range of local official health work.

In East Sussex, England, there is complete union of public and private health work throughout the county. The medical officer of health is elected by the county borough. His appointment must, however, be approved by the Ministry of Health of England. All the East Sussex Queen Victoria Jubilee Institute nurses and village nurse-midwives work as part of a single staff which includes also all nurses and midwives on the

official payroll. Official committees, also elected by the people, are responsible for the health of school children, the antituberculosis program, and maternity and child health; they serve too as advisers to the medical officer of health who is, of course, chief of staff.

Although these four projects differ greatly, each illustrates the part played by the private agency in the development of a public health program. It may be—and experience justifies the expectation—that as time goes on the private agency will disappear altogether from these four pictures, but it is safe to say that the health work which is now being done could not at the present time be undertaken by the local official health agency unaided.

A Day with a Rural Nurse in the Southern Mountains

It may help to an understanding of rural nursing to interrupt the study of its aims and methods at this point with the story of a negro public health nurse's daily application of these methods to family visiting in the mountains of the Southern United States. The region of Nurse Emma's labors is one of mines, smelting works, and a large negro population. A day which I spent with her in a round of visits is a high point of memory. We climbed long hills, passing small schoolhouses on our way, jolted mercilessly in our Ford car, in and out of the deep ruts in the road, avoiding although not always escaping some great boulder by the wayside when we were obliged to pass a team of mules. My companion not only drove the car but kept up all the way a running commentary on the country, the people, and

her work. Her comments were exceedingly interesting and both keen and intelligent. We visited first a mother who had been following Nurse Emma's directions faithfully in caring for the eyes of her new-born baby, a victim of ophthalmia neonatorum. The eyes were almost well. Nurse Emma was a welcome visitor, and the mother was ready to listen to her suggestions in regard to the care of the older children.

The next visit was to a home near some smelting works to see a little girl of eight who, without much doubt, had been exposed to tuberculosis, of which her mother had lately died. It was all-important to get the child to town for a physical examination. This involved, however, the complete reeducation of the father, who did not think such an expedition necessary or desirable in any way. There he sat on a fallen tree trunk, whittling as he talked with a neighbor. He greeted us, but without much enthusiasm, and we went into the cabin where we found the little girl. In a few minutes it developed that she had a serious grievance, for she had been sent home from school because she had declined to take off her woolen sweater. The father was brought into the conversation that followed. The nurse exhibited notable finesse, showing her keen perception of character and her understanding of the racial characteristics of the man with whom she had to deal. From the start it was quite obvious that a teacher who meant well had blundered, and that the child should have been allowed to keep on the clean warm garment over the cotton dress. However, Nurse Emma did not adopt the attitude of sympathy with the father and daughter until she had gained an admission from him that he ought to have been patient with the teacher's mistake, waited for the public

health nurse to straighten things out, and not "kicked up a fuss in the school" by taking the stand that the little girl should not go again.

"One of my best fathers and to disappoint me like that! Don't you ever do that way again, y'hear me?" Thus she admonished the now smiling father as we drove off to interview the teacher, who lived near the schoolhouse a long way off over very perilous ruts and up a steep incline.

It will perhaps take a good many visits to this father before the child's trip to the city can be arranged, but when it is made there seems a pretty good prospect that father and daughter will be ready to follow the doctor's advice, that is, if Nurse Emma seconds this advice.

We did not find the negro teacher at home, but her little crippled boy was there and ready and evidently equal to delivering the message from the nurse, whose word "went" in this family also. After leaving this home we bounded over rocks and ruts once more, and finally the Ford ran away down a hill, quite off the road by now, and brought up triumphantly, having been saved from further descent by bumping directly into a tree. By this time, I, too, had complete confidence in Nurse Emma. I did not even stop to see what had happened to the Ford, but went into the house of the next patient; for, needless to say, we had come to a halt almost precisely opposite her front door. Although there had been no one in sight when we arrived, help must have sprung from the earth or the rocks; for when we came out of the house there were three men standing about, pleased at having been of assistance to the nurse. Their method had been unusual but effective: they had simply cut down the tree which impeded the car's progress.

The last household visited afforded an interesting example of case finding. A hint regarding the young husband had led to a call from the nurse; this resulted in his going to a doctor, who made a diagnosis of gonorrhea. Nurse Emma also discovered that his wife was pregnant and greatly in need of medical attention. Here Nurse Emma was doing an excellent piece of public health nursing, but one fraught with great difficulty. It was necessary that the young wife have treatment regularly at a dispensary many miles distant from her home and she had no means of conveyance. The husband knew a man who drove a taxi and he had promised to borrow this car every clinic day in order to take his wife to the dispensary. But after a visit or two his interest waned, and it was only by the most patient and persistent effort that Nurse Emma was able to keep him to his good intentions throughout the long period during which the treatments were necessary.

On our way down from the home we met the husband, and it was interesting to observe his respectful attitude toward Nurse Emma. She is a power in her locality; and difficult as her life must be, she is a contented young woman. She could not, I thought, have done such good work if she had not herself lived through some difficult experiences and come out of them well. When I asked her how she persuaded the young man to go into town for treatments she told me quite frankly that she had appealed to a well-known negro fear of lameness. "Do you know So-and-so," she asked the young man, "going on crutches round the streets of B——? Well, you'll be like him if you don't go, and go soon." And this warning had had the desired effect.

We returned to the city minus a hat and with a record

of running into three cars and a tree; but no one seemed to mind, least of all ourselves. No white nurses I have ever known, granted that their preparation for public health nursing was as limited as hers, could have performed that day's work as well as Nurse Emma had done. These incidents in the life of a colored public health nurse on a busy day are both interesting and enlightening, for they show unusual aptitude for teaching and unusual adaptability to difficult home situations which affect health: this, on the one hand. On the other hand, they show how greatly Nurse Emma would have profited by special preparation in public health nursing and adequate public health nurse supervision. So good were her teaching methods that, as a result of her visits to one home, a baby having ophthalmia neonatorum was cured; but it was a matter of pure chance that others had not been infected by Nurse Emma herself, or by the baby's mother, for Nurse Emma had never been taught the very elementary principles of asepsis as applied to the irrigation of infected eyes. She has such a "way with her" in teaching her own people that through her efforts a little girl who had been in direct contact with an active case of pulmonary tuberculosis returned willingly to school; but the larger questions of this child's effect upon the other pupils and of the status of this particular school in relation to the local tuberculosis situation, as they appeared to a casual visitor, never seemed to enter her mind at all.

Great returns may be expected when good nursing schools for colored girls are established throughout the South and especially when the preventive aspects of nursing are emphasized from the beginning in these nursing schools of the future. There is a great and expanding

field for negro nurses among their own people. Young negro women who have finished high school, and who have in some instances been to college, are going into such professions as teaching and library work; why do not more of the best women of the race prepare themselves for public health nursing?

Progress in Formulating Standards for Rural Nursing

The differences between public health nursing in the city and in rural communities are perhaps greater than one would at first suppose. Since it has been shown that the methods of the nursing staff in a congested city population produce good results, why, we may ask, cannot those methods be applied in the county units? In the child health demonstrations of the Commonwealth Fund a method of public health nursing similar to that employed in East Harlem is being tried out in so far as it is possible to reproduce the favorable conditions which prevail in East Harlem in the counties which are, for the period of the demonstration, being given substantial financial help by the Commonwealth Fund. However, even in these favored areas of our rural communities there are geographical, political, social, and economic differences worth noticing.

The organization of almost every state health department is unlike every other, and public health nursing is so new a branch of the state program that it is seldom found to be completely standardized either in the state health office itself or in the county offices where the chief nurse of the state might be expected to exert a strong influence, even though a democratic state policy may not

have given her any direct administrative function in the counties. Another factor too that makes for unstandardized public health nursing procedures is that political appointments are still frequently a handicap in health work in rural communities.

All rural public health nurses will find inspiration and help in a recent publication edited by Professor Ira D. Hiscock of the Yale School of Medicine,[9] which is full of invaluable suggestions for the standardization of rural public health nursing. A division of rural public health work into six main activities [10] gives public health nursing an independent place of its own. The principles advanced are, for the most part, those proposed in the Appraisal Form of Rural Health Work, as prepared at the direction of the Committee on Administrative Practice of the American Public Health Association. The public health nurse divides her time among the following main functions: prenatal and maternal care, infant welfare, preschool hygiene, school hygiene, and the control of epidemic diseases, tuberculosis, and venereal diseases.

Professor Hiscock has outlined recommendations, gathered from the experience of many public health nursing associations, as to the proportion of public health nursing visits likely to be productive of results measurable by reduced morbidity and mortality rates.[11] These are of such great value that I shall summarize them briefly here.

[9] *Community Health Organization,* American Health Congress Series, Vol. 2, Part 4. Copyrighted by the American Public Health Association, 1927.

[10] These are, (1) administration and records, (2) communicable disease control, (3) child hygiene, (4) public health nursing, (5) inspection, (6) laboratory.

[11] *Op. cit.,* pp. 107-115.

1. *Prenatal Care.* In a rural population of about 30,000 there should be held one semimonthly medical conference at the largest town and, at different places in the district, two other monthly conferences. These would care for 250 visits per 1,000 total births in addition to the follow-up visits to postnatal cases.

2. *Infants.* With 24 births per 1,000 population, or 720 in a population of 30,000, possibly 25 per cent should be under the care of a well-organized health conference, visiting it at least six times yearly. There should be 2,500 visits to conference or doctor by infants under one year, per 1,000 live births.

3. *Preschool Children.* There should be 200 visits to conference per 1,000 preschool population, about 630 in a population of 30,000; at least 100 visits to homes per 1,000 preschool population. The preschool population is estimated at 10.5 per cent of the total; each year 20 per cent of the preschool population ought to be immunized against diphtheria through the cooperation of general practitioners, and the establishment of immunization clinics should be developed. Child contacts (nonimmune) of scarlet fever should be controlled for seven days.

4. *School Children.* In a population of 30,000 there will be approximately 4,800 grade children requiring supervision.

5. *Control of Epidemic Diseases.* There should be three visits per case for diphtheria and typhoid; two visits per case for scarlet fever; one visit per case for measles, whooping cough, poliomyelitis, and meningitis.

6. *Tuberculosis.* Experience has shown that the yearly number of new cases of tuberculosis may be expected to be approximately three times the annual number of deaths from tuberculosis. If it may be assumed that the tuberculosis death-rate is 80 per 100,000, the annual number of new cases may be put at approximately 72. But if the ratio of new cases to deaths should be 9 to 1, as it was found to be at Framingham, then the new cases might be expected to total about 216 annually. There should be examination of all cases, suspects, contacts, and groups of persons particularly susceptible to the disease. A standard of 1,000 clinic visits per 100 deaths is reasonable for county service under present conditions, with a ratio of three visits per patient registered in the previous year.

There should be 2,000 nursing visits per 100 deaths, or 480 visits; 10 per cent of the total tuberculosis field nursing visits should be made in behalf of postsanatoria cases.

7. *Venereal Diseases.* Through notification of cases there should appear about 400 cases of all kinds per 100,000. Ten visits per new patients registered should be allowed. A system of follow-up is needed to show the ultimate disposal of cases.

These suggested outlines for the public health nurse who is a part of a county health unit are interesting in themselves and particularly instructive in that they show how far it has already been possible to measure the effect of a nursing program and to estimate the value of its component elements in the inclusive program of the county. They will be most helpful to the supervising nurse who is at liberty to develop her own department on the lines that seem to her most efficient.

Perhaps the chief value of Professor Hiscock's standards for visits to types of cases or to age-groups in the community lies in the fact that they are related so closely to the remaining five elements in a successful county health program.

In Cattaraugus County, New York, where an intensive piece of work is in progress under the direction of a committee of the Milbank Memorial, the following standardized budgeting of a nurse's time has been published:

Activity	*Per Cent of Time*
Home visits	28
District health conferences	30
Service in schools and clinics	11
Staff meetings and cooperative visits	10
Travel	21
Total	100

In this county the time spent in work with mothers and babies, including home visits and conferences, has increased from 33.3 per cent of the nurse's time to 43.7 per cent after one year's observation of relative value.[12] Such visits serve a twofold purpose: first, to arouse the interest of leading citizens and, second, to give parents practical information about preventive measures for mothers and babies.

Public Health Nursing Census an Aid in Formulating Working Programs

In 1926 the National Organization for Public Health Nursing completed and published a census which provides exact information on many points in the development of public health nursing in the United States. In the formulation and subsequent building up of a public health nursing program for any locality this census may be employed to great advantage. It should also serve as a valuable source of information for almost any given study in a given state.[13] Let us suppose that the maternal mortality rate is high in the state of New Hampshire and that a study of the underlying causes of this high death rate is to be made. One would like to know what the public health nurses are doing in this state to care for mothers before, during, and after child-

[12] From a privately distributed pamphlet issued by the Milbank Memorial Fund, entitled "Relating to certain phases of the organization, health services, and vital statistics of the Cattaraugus County Demonstration and the Syracuse Health Demonstration," p. 62.

[13] In a paper read at the National Health Congress of 1926, Elizabeth Fox, past president of the National Organization for Public Health Nursing, discussed certain points on which the census sheds light. (Reported in *Public Health Nurse*, August, 1926, pp. 467-469.)

birth, and, further, to know what information the public health nurses may have about patients who are not under their care.

Such a study will involve an intimate knowledge of the people and of the conditions under which they live; of the laws bearing on maternal and infant care; of the cost of such care and of the ability of the people to meet the cost of the agencies through which the care is administered; of the doctors, nurses, and health officials or social workers concerned with its administration; and of the institutions where the babies are born. Who cares for mothers in childbirth in New Hampshire, under what conditions do these practitioners work, and how were they educated for this work? These and other details of the lives of doctors and nurses who care for mothers in the puerperal period have a bearing upon the maternal death rate in New Hampshire. We need to know about the homes of the people, the schools where the children go, the working places of their elders, and whether or not public opinion in regard to preventable deaths in childbirth has been aroused. What does the everyday man and woman think about it?

Whoever undertakes this study will come to know doctors, nurses, and the families they serve, and in this way will collect data which, tested and tested again by discussion with those most intimate with the facts, will become finally a reliable body of information. Such a body of information will be saturated with the intimate personal experience of many people.

The Public Health Nursing Census would come to the hand of the investigator as an invaluable reference book containing the name and address of every public health

nurse in the state and giving the following general facts:

1. On a given date there were in New Hampshire:

Population	443,083
Per cent of United States population	4.9
Population per square mile	0.4
Number of families	98,463
Negroes	621
Per cent of rural population	36.9
Per cent of foreign-born	20.8
Live births	9,309
General birth rate per 1,000 population	20.8
Deaths under 1 year per 1,000 births	93.2

We find that there were:

a. 71 public health nursing agencies and 120 nurses.

b. 80 per cent of these agencies had only one nurse, which puts 48 per cent of all the public health nurses into this group.

c. 17 per cent of the agencies had two nurses, putting 33 per cent of all nurses into this group.

d. 3 per cent had ten or more nurses, so that only 19 per cent of all nurses were in this group.

2. If so large a proportion of the New Hampshire public health nurses are working alone in an agency, as 48 per cent are doing, we are interested to know whether any method of educational supervision is provided for them. The census gives the following figures on supervisory service:

a. Total number of nurses	120
b. Indirect supervision	6
c. Direct supervision	114
d. Ratio	1 to 19

We cannot, of course, assume that this ratio has any direct bearing upon individuals supervised, since the 120 nurses are so largely working in localities apart from any contact with other nurses.

3. Twenty-four of the public health nursing agencies are official and 47 unofficial.

4. Forty-four of the nurses are in the official and 76 in the unofficial group.

5. No one of New Hampshire's ten counties is without a public health nurse. This is an unusual record for any state, but again we must not assume that New Hampshire has an adequate public health nursing service, for with the mountains, hills, and lakes of the state separating one community completely from another, this is far from true.

6. In all New England there are but 5 negro nurses.

7. The number of people to one public health nurse is 3,692.

8. The area is 77 square miles to a nurse.

9. The types of public health nursing service rendered in the seventy agencies are as follows:

Type of Service	*No. of Agencies*
General care of the sick	46
Maternal care	47
Tuberculosis work	33
Communicable disease control	17
Venereal disease control	19
Care of preschool children	46
Care of school children	51

10. Of the 71 agencies, 2 give curative care only, 21 give instructive or preventive service only, 47 give curative and instructive service.

11. Of the 71 agencies, 21 are supported by public funds, 9 by private funds, and 39 by combined public and private funds.

We find by consulting the census that 21 of the 120 public health nurses are in the largest city. Twenty-eight of them are in cities having a population of 10,000 or over, which leaves only 71 for all the rest of the people. The distribution according to cities is as follows:

Manchester	21
Nashua	8
Concord	6
Berlin	2
Portsmouth	3

Dover	4
Keene	3
Laconia	2

All this will be useful information with which to begin a study of maternal care, and it will be of great service in the preparation of public health nursing programs.

Preparation for Rural Nursing

As a rule the most urgent question in the mind of the rural nurse who is a part of an official health unit is, "How can I spread my activities out to cover even half the demands made upon my time and still satisfy myself that my work is thorough and effective?" The rural public health nurse needs thorough preparation for her work, and only after she has had a good deal of experience in addition to adequate preparation will she gain the poise necessary to a patient waiting until all the contributing factors are ready to permit of the development of her own branch of the service.

There are 3,045 counties in the United States, and only about one-tenth of them have full-time health service. In a movement so young it is not to be expected that either the full-time health officer or the full-time public health nurse will be found to have been especially well prepared for the work. There are exceptions, of course, but frequently this lack of special preparation exists. At present salaries are low and promotion is uncertain since it is often limited by politics. The higher salaries in health positions are often not adequate to secure the type of man or woman urgently needed. It is for these reasons among others that one so frequently finds a fine nurse executive, educated and experienced in

public health nursing administration, who has left an official position of importance to work under private auspices. The state of Texas has only twenty public health nurses in its whole vast area, yet it demands a three months' probationary service during which the nurse receives the nominal stipend of $50 a month. At the end of the three months she is paid $125 a month and at the end of a year $150 a month.

The different states vary greatly in their requirements as to special preparation for public health nurses. Often appointments in rural nursing are made with little regard to the training of the applicant. This ought not to be so, for there is no position in public health nursing work in which the best experience and most thorough basic education is more needed than in rural health work. Rural nurses work alone in their scattered areas so much more than any other group of public health nurses, and the number of public health nurses on a county unit staff must necessarily increase rather more slowly than in town or city, for public opinion is not so readily formed nor so promptly acted upon in the country. Furthermore, rural nurses do not have the advantage of those conferences and meetings which do so much to keep the city nurses alert to the best methods of practice. It follows, then, that the quality of the rural nurses employed must be excellent.

Of equal importance is the supervision of these workers, for it is through the supervision of public health nurses by public health nurses that efficient standardized nursing services will be developed. Certain of the limiting conditions in rural nursing today, such as inadequate pay, uncertainty of advance for merit, and an improper use of the nurse's time, would

be eliminated if a supervising nurse were assigned to a given number of rural nurses. This officer, in addition to her supervisory work, would arrange conferences with neighboring nurses, thus stimulating discussion and comparison of methods and practices which would result in a far more efficient service.

A public health nurse who understands her responsibilities may develop her program to better advantage under an administration unit where a health officer leaves her free to carry on her work. Recently a public health nurse who has had a long experience in rural nursing pointed out the fact, indisputably true, that in some communities, where there was not a full-time health unit and where, therefore, the general program for public health service was more limited, the public health nursing service *per se* was distinctly better than in many full-time health units familiar to her. This is natural, although unfortunate, since the full-time health officer, if he has not been well prepared for his work, is likely to use the nurse for simple routines, such as checking over records, or applying iodine and alcohol to arms after immunization treatments—services which other persons might easily perform. The nurse, if she herself is unprepared for her work, falls all too easily into a habit of doing what she is told without much thought of her special rôle in the county program.

A public health nurse will often derive much benefit from a visit to the work of other nurses in this field. The following program was recently followed by a group of nurses who were the guests of the State Department of Health in Alabama:

1½ days visiting the various bureaus of the State Department of Health.

½ day visiting cooperating state departments (education and child welfare)

11 days in Dallas County.

1st day. *A.M.* Office conference and explanation of unit organization.

P.M. Office conference with cooperating agencies; county and city child welfare, probation and attendance officers, county home demonstration agent.

2nd day. *A.M.* Observation of work of negro nurse in the city negro institutions.

P.M. Schools of nursing and hospital cooperation.

3rd day. Rural sanitation: discussion and demonstration (county sanitary inspector).

4th day. *A.M.* Examination of school children (demonstration health officer and nurse).

Office records and letters to parents.

School lunches.

P.M. Health education: class work in Methodist Orphanage directed by public health nurse.

5th day. *A.M.* Office conference on work observed.

Venereal disease clinic.

P.M. Mosquito control work (health officer): office discussion of problems and methods; observation of application of methods.

6th day. Field work (with white nurse).

Home visits: pellagra, postnatal work.

Adult class: home nursing.

7th day. *A.M.* Demonstration of mosquito control work.

P.M. Hospital.

Cooperation in work with crippled children.

8th day. Field work (with negro nurse).

Home visits: prenatal, infant hygiene, preschool, school follow-up, adult.

9th day. Field work (with white nurse).

Home visits: school follow-up, communicable disease, tuberculosis, postpartum.

Group meeting: infant care.

10th day.		Field work (with negro nurse).
		Home visits: school follow-up, crippled children, infant hygiene, social service.
		Group meeting: prenatal care.
11th day.	*A.M.*	Office work of office secretary.
		Final conference on work of week.

The best results were obtained when one visitor only accompanied the nurse on a visit. A daily conference of visitors and supervisor for a discussion of the observations of the previous day and of special field work for the day was found mutually helpful.

Our public health nursing courses have very generally failed to prepare rural nurses for official health work. Is this, among other reasons, because the courses have not taken into sufficiently serious consideration the need for supervised practice in an administrative field similar to that in which rural nurses are to work? If so, such a field should be developed, and other obstacles to securing suitable preparation for rural public health nurses should be studied and overcome.

CHAPTER III

SOME ASPECTS OF PUBLIC HEALTH NURSING ADMINISTRATION

Official Control in a Large City—Toronto [1]

THE Municipal Department of Health of one of our neighboring Canadian cities—Toronto—conducts a public health nursing department which has come to be known as a model in many ways. Bedside care is not, to any appreciable extent, a part of its program; but with that important exception, the personnel of this department comes into a more complete and effective relationship with the families of the city than is perhaps at present true of the public health nurses of any city in the United States.

The most important element in Toronto's public health nursing service is undoubtedly the unification of all its activities under the Chief Officer of Health of the city, Dr. Charles Hastings, a distinguished leader who has held office uninterruptedly for twenty years. Dr. Hastings' plans for the development of public health work and the prevention of disease have been wide and farseeing, so that Toronto has a superior group of public health nurses under the leadership of a director who heads the division of nursing of the Department of Health. The responsibilities and privileges of this director are in all particulars similar to those of the heads

[1] As of the year 1925.

of other divisions of the Health Service and to her, in large measure, is due the success of the public health nursing movement in Toronto.

Toronto is divided into eight public health nursing districts in each of which there is a local health office. Six of these offices are situated in the police headquarters of the respective districts and two in the offices of social agencies. Each local health office is a large cheerful room, with desks for ten or twelve nurses, telephone, bulletin board, technical books and magazines, and an adjoining dressing room. In addition, there is a second room where a hot luncheon is served daily, during which a staff conference takes place.

Each local staff is composed of a chief nurse or superintendent, a clerk, and a varying number of staff nurses, many of whom are graduates of the course in public health nursing given at the University of Toronto. In addition to the nurse superintendents who, as the name implies, are the executives of the eight district health offices, there are also field supervisors of special services such as child health, mental health, and others, whose highly individualized knowledge must be acquired by a wide and intensive experience in their own field of work. A doctor of the Department of Health is assigned to each district.

The members of the district staff gather daily at the local office for a half-hour luncheon period and an informal conference at which matters of common concern are discussed. It is a time when headquarters' officials may be sure of finding everyone present. Frequently the special supervisors join the local groups at this time. Each day a messenger is sent from City Hall to the local offices with a portfolio containing official notes, orders,

and reports, and this portfolio goes back by the same messenger, filled with routine dispatches from the various stations. Particularly efficient is the method of presenting to the local offices interesting articles in the current health publications. These publications are sent from the central public health nursing office at City Hall in systematic order from one local office to another, each nurse checking off after reading. Articles of particular interest are often marked by the director or special supervisor at City Hall.

The superintendents of nurses meet at least every two weeks in the district office to formulate policies and to confer upon details of administration. The director of the division and her assistant usually attend these conferences. The supervisors meet formally or informally at the City Hall when necessary. A joint conference of superintendents and supervisors is held every two weeks, with the director of the division or her assistant presiding. A representative from the division of records and statistics is always present. The deputy officer of health is notified of all meetings and attends occasionally.

The entire public health nursing staff of the Department of Health meets at regular intervals in the City Hall for discussion, comparison of experiences, and instruction from the Chief of the department, Miss Dyke, who in a very real sense leads the group. The plan on which the nursing work is carried out is a generalized one, and each staff nurse is expected to perform in every home all the public health nursing services the family may need at the time of her visits, a task which demands a knowledge of many kinds of public health work. We shall see how easily and simply the system works as we

turn now to consider the daily routine of the public health nurses.

Each nurse has her own distinct area for health visiting, and other nurses do not poach on her preserve. If her area contains a public school that too is her responsibility, though many of the children may come from outside the limits of her district. If they do, she refers the necessary home visiting to the nurse in whose area the children live. A nurse spends from 27 to 28 per cent of her time in the public school within her area, reporting there every morning at 8:45. The nurses (not a doctor, as in some other agencies), under the direction of the district medical officer, make health inspections in the classrooms and in their offices in the school building for the purpose of exclusion or readmission of pupils. Doctors make periodic physical examinations, and dentists make a yearly dental examination of each child in the classroom. The latter is followed by a talk on oral hygiene and often by a demonstration of the proper method of brushing the teeth. Perhaps more notable than any other service in the Toronto schools is this of mouth hygiene. The usual 90 per cent of dental defects of schoolchildren has been reduced, as shown in a recent finding in a Toronto school, to 56 per cent. Teachers, dentists, nurses, pupils, parents, doctors—private or city—all appear to be working intelligently and with a uniform plan towards the goal of health which in Toronto seems within reach of every child.

The public health nurse's afternoon is given over to home visiting, visits to tuberculosis sanatoria, and attendance at tuberculosis clinics, well-baby clinics, prenatal clinics, and clinics for preschool children. These are conducted by the Department of Health in close co-

operation with the departments of pediatrics, obstetrics, and epidemiology at the Medical School of the University of Toronto.

Home visiting is always carried on by the nurse in whose area the house is located, as it is a cardinal principle of the Toronto Public Health Nursing Department to preserve the home from invasion by many health teachers, to the end that the full effect of continuity of teaching may be felt and also that the intimate relation established by personal contact may carry its influence in that teaching. Teaching mothers the care of children having communicable diseases, the exclusion of these children from school, and authorization for their return come within the duties of the nurse.

Under one direction, then, we find nurses who are carrying out all the services enumerated below: prenatal care at clinics and home visits to new-born babies to insure birth registration; baby conferences, with Department of Health doctors in charge, and home visiting as an essential part of the teaching plan; supervision of the preschool child, both at conferences and in the home, or home visits to children of this age whose mothers have placed them under the supervision of their private doctors; health inspection and teaching of health laws and health habits in the public schools; communicable disease detection, exclusion of the infected from school, release from quarantine, readmission to school, and perhaps more important than all, assistance in the complete periodic physical examination of every schoolchild and the recording of findings, which insures oversight of the child as long as he remains in school; care of the tuberculosis patient and protection of his family and neighbors, cooperating in this with the patient's family, with

private doctors, and with sanatoria; assistance at the Department of Health tuberculosis clinics, of which there are six held at hospitals, home visits to clinic patients, visits to the sanatoria at regular and frequent intervals, and close supervision of the home and neighborhood from which the patient comes; follow-up visits to former hospital patients for purposes of social readjustment; visits to certain families, in connection with a welfare branch of the Department of Health, to prevent them from becoming or remaining public charges; prenatal care at clinics with home visits for instruction and observation throughout pregnancy.

The care of the sick does not come into the scheme for family health laid out for the Toronto nurses. Close cooperation with the nurses of the Victorian Order, which means a careful passing to and fro of cases, is the method pursued where there is sickness. An expectant mother under the care of a Department of Health nurse becomes the patient of a nurse of the Victorian or the St. Elizabeth order when she is confined and for the period of her stay in bed, but becomes again the charge of the Department of Health nurse when she brings her child to the baby clinic. The chief of the pregnancy clinics of the Department of Health is the professor of obstetrics at the Medical School of the University of Toronto. Through this most valuable cooperation the mothers attending the clinics have the direct personal supervision of an expert in maternal care, who is ready to give the benefit of his knowledge to the private doctor who may be engaged for the delivery.

The nurses also assist in the control of venereal diseases. Enforcement of the Provincial Act pertaining to the control of these diseases is directly under the chief

officer of health. The special supervisor, a public health nurse in charge of the detail tasks of such enforcement, has two avenues of work, one through her official connections with the Court of Domestic Relations and the Juvenile Court, the sessions of which she attends, and the other in an educational capacity through direct contact with the whole staff of nurses. Compare such a unified plan with the procedures which prevail in many cities no larger than Toronto.

Since all the public health nursing work is an activity of the city government, and city budgets cannot be increased overnight, the health education program cannot be expanded as rapidly as the needs demand. Prenatal clinics are open to all, but home visits at standard intervals cannot possibly be an inviolable routine procedure in a city of 530,000 unless a very large staff of public health nurses is employed. Nor can there be maintained a standard in the established interval between home visits in connection with the well-baby and preschool clinics, for these too are open to all the babies and preschool children of Toronto. However, as each nurse has her allotment of homes in which the babies live, she will keep as close a connection with each home as her time permits. The special supervisor will watch results closely, and the executive local superintendent in each office will know how adequate the supervision is at any given time.

For better health for its 500,000 people, the city of Toronto was, at the time of which I write, spending $1.67 per capita, exclusive of expenditures for hospital care. The results of this health work are on record in the files of the Public Health Bulletin of the city Department of Health, and may be studied there; but

since lowered death and sickness rates throughout an entire community can be brought about only through the intimate contacts with families in their homes and with children and teachers in the public schools, which public health nurses are able to make so successfully, the story of the staff nurse in Toronto becomes especially interesting.

Division of Public Health Nursing Functions between Private and Official Agencies, Boston

In the large city, as in the rural area, no logical line of demarcation can be drawn between the functions of the official and the private agency in the field of public health nursing. The city of Boston affords an example of a municipality in which home nursing service is provided by both types of agency: the city Department of Health conducts communicable disease nursing, inclusive of tuberculosis, and infant welfare and preschool nursing; the Department of School Hygiene is responsible for the health nursing for the public school population; while the Community Health Association, a private organization, carries out in close cooperation with these official organizations a general family health program.

The nursing staff of the Department of Health includes a director, six supervisors, and seventy nurses. Arrangements have been made whereby the students of the School of Public Health Nursing of Simmons College may receive their field experience in child hygiene work with the nursing service of the Health Department. The nursing staff of the Department of School Hygiene consists of a supervisor and fifty-five staff nurses, thus

giving for the 102,000 children in the public elementary and intermediate schools a ratio of one nurse for less than 2,000 pupils. The nursing organization of the Boston Sanatorium [2] includes a director, a supervisor, and thirty-nine staff nurses. The nurses assist in the out-patient department of the institution and do home nursing, which involves a certain amount of bedside care.

The Community Health Association was organized in 1922 through the amalgamation of two private agencies, the Instructive District Nursing Association and the Baby Hygiene Association. The work of the Community Health Association is family health service, including bedside nursing. The most important of its activities today as in the past is the maternity program, consisting of prenatal work, service at confinement, and postnatal work. It carries out practically all the prenatal work in the city done by public health nurses, a concentration that makes possible uniformity of standards and an economical and efficient service. A large proportion of the time of the association nurses is given to the care of acute diseases; and an increasing number of visits are being made to chronic patients. Through an understanding between the association and the Department of Health, visits for bedside care may be made in certain instances by nurses of the former organization to cases of so-called minor communicable diseases which are discovered in the course of their routine work. The association nurses also take part in carrying out the nutrition program of the organization, the orthopedic work, and the mental hygiene work. The nursing staff of the asso-

[2] Now included under the Department of Health.

ciation consists of 4 specialized supervisors with 4 assistants, 15 station supervisors with 10 assistant supervisors, and 93 staff nurses.[3]

In the year 1920, two years before the amalgamation of the Baby Hygiene Association and the Instructive District Nursing Association, an analysis was made of the work of the latter organization, and it has seemed worth while to publish here some part of that analysis.

Work of the Boston Instructive District Nursing Association in 1920

For the year 1920 the association reported 36,660 patients, nearly 10,000 more than in 1919, an increase unprecedented in the history of the association; 323,772 visits were made as compared with 247,268 in the preceding year. To meet the increase of work 23 nurses were added to the staff, which then numbered 114 salaried nurses. There were also between 15 and 20 public health students assisting in the work. The total expenditures for 1920 were $215,742 as against $151,342 in 1919. The nationalities of the patients receiving care during 1920 are shown in Table 1, page 62.

For convenience, the service is divided into three sections: (1) acute and communicable diseases, (2) conditions of maternity and infancy, (3) chronic illness.

Acute and Communicable Diseases.—Acute and communicable diseases are classified together because the latter are generally acute. In the year under discussion 58.56 per cent of the work of the association was in con-

[3] The material quoted above is a condensation of Sections I and II of *The Community Health Association and Its Relations to Boston's Health Program,* by C. E. A. Winslow, Katharine Tucker, and Ira V. Hiscock (Boston, 1926).

nection with diseases of this category. Of the cases in this group 5.58 per cent were pneumonia, 6.45 per cent communicable diseases of children (not including the two principal diseases, scarlet fever and diphtheria), 11 per cent typhoid fever, and 4.97 per cent bronchitis. The pneumonia patients numbered 1,463, and of these, 191, or 13 per cent, died. The figure 1,463 includes the patients who were sent to hospitals. If we exclude this number and consider only those patients cared for in their own homes throughout their illness, we still find the percentage of deaths as small as 14. In one of the large Boston hospitals during 1920, there were 187 pneumonia patients, with 88 deaths, a mortality of about 47 per cent.

TABLE 1.—*Nationalities of the Patients Cared for by the Boston Instructive District Nursing Association in 1920*

Nationality	Per Cent of Total
American	35.53
Italian	20.50
Irish	17.02
Jewish	8.40
Canadian	5.12
Russian and Polish	3.90
English and Welsh	1.54
Scotch	.74
Swedish	.74
German	.69
French	.21
Other Nationalities	5.00
Unknown	.60

Whether or not a pneumonia patient ought to go to a hospital depends chiefly on home conditions. If an intel-

ligent member of the family can give him constant care, he may be better at home than if subjected to the strain of removal and of adapting himself to hospital environment. His dread or fear of a hospital is often a determining factor. Space, air, sunshine, freedom from mental disturbance, regularity of nourishment, are all necessary to the pneumonia patient, and it is surprising how often a resourceful nurse can secure these essentials under unpromising conditions. The nurse, on her first visit, will select the member of the family who seems most teachable, and to this person, after careful direction as to the care of the patient and protection of the household, she will intrust the patient throughout his illness. In this way, with visits daily or twice a day from a nurse who teaches on every visit, not by word only, but by repeated demonstrations of the simple nursing procedures upon which so much depends, a patient in his own home may be very successfully cared for. Children constitute a large percentage of the pneumonia patients, and where conditions are not too difficult they can, under supervision, be properly treated at home. A mother suffering from pneumonia will often do better at home with her family than in a hospital, although a good deal of effort is often required on the part of the nurse for the satisfactory adjustment of home conditions. Sometimes the nurse must find a relative or a friend of the family who will come and stay in the house during the illness. There are circumstances, however, under which a pneumonia patient must be hospitalized; a typical instance is the man living in a lodging house. The nurses cooperate with many other agencies to secure convalescent care away from home for their pneumonia patients. Table 2 lists, according to age, the pneumonia patients cared for

by the Boston Instructive District Nursing Association in 1920.

TABLE 2.—*Pneumonia Cases Cared for by the Boston Instructive District Nursing Association in the Year 1920*

Age Groups	No. of Cases	Per Cent of Total	No. of Deaths	Percentage of Fatality
Total, all ages	1,463	100	191	13.0
Under 1 year	173	11.8	29	16.7
1 to 2 years	275	18.8	41	14.9
2 to 5 years	269	18.4	15	5.2
5 to 9 years	172	11.8	8	4.6
10 to 15 years	41	2.8	2	4.9
Total under 15 years	930	63.6	95	10.2
15 to 45 years	302	20.6	33	10.9
45 years and over	231	15.8	63	27.2
Total over 15 years	533	36.4	96	18.0

It will be noted that almost 64 per cent of the patients were children and that 10 per cent of these died, whereas among the remaining 36 per cent, 18 per cent died. Again separating the groups, we find a case fatality of 10.9 per cent in the 15 to 45 year group, and the highest fatality of all, 27.2 per cent, among the group of 45 years and over.

With typhoid fever cases, nurses do not like to take the responsibility of caring for patients at home, because there are so many ways in which an untrained person may break the technic of nursing, and by so doing carry the living typhoid organism to some other member of the family. It is difficult for a person unaccustomed

to sickness to realize that washing the hands in the special basin set apart for that purpose every time the patient, or anything that has come in contact with the patient, has been touched, is the only way to be sure that furniture or dishes or food will not be contaminated and become the means of infecting others. Doctor and nurse are generally united in trying to get typhoid patients into hospitals.

Maternity Cases. Twenty thousand babies were born in Boston in 1920. An obstetrician, on being asked whether it is safe to permit maternity patients to be cared for by nurses who are at the same time taking charge of other patients, doing surgical dressings, giving bedside care to pneumonia patients, or looking after a child with measles, would reply, "No, it is not safe." Yet this is the method employed, and with unquestionable success: there has never been a case of cross infection, and the maternal death rate has been reduced materially since the nursing program has been in effect. This statement is based on the following facts: the records of the health department show that there were in Boston in 1920 seven maternal deaths for every 1,000 births; while among the mothers cared for by the maternity service of the association there were, in that year, only two deaths for every 1,000 births, which means that the lives of 100 Boston mothers would probably have been saved had they all had the benefit of this service. We believe, moreover, that these results must be attributed primarily to the nursing service, which maintains a definite standard, while the medical service necessarily varies with the doctor. Twenty-six per cent of the maternity service was for the Lying-in Hospital, 3 per cent for the Jewish Women's Maternity Association, and the remaining 71 per

cent for private doctors, with widely varying degrees of skill. If the results had not justified this method of generalized nursing, it might well be questioned whether all the nurses of a large public health nursing staff are capable of giving successful maternity nursing care. The 114 nurses constituting the staff that has achieved the results quoted have had only the usual maternity training in hospitals; yet associations employing special nurses for maternity work have shown no better figures.

When a new nurse is enrolled on the staff she is taught the maternity technic by the station supervisor and is carefully directed in its practice. The station supervisors, realizing the importance of scrupulous observance of the established technic and the value of prenatal nursing care, see to it that, in the pressure of community sickness, no detail in this department of the work is overlooked and that prenatal visits are not neglected. In the staff conferences there is frequent discussion of the maternity service, and emphasis is laid on the importance of routine procedures.

Inasmuch as 23 per cent of the entire service of the association is maternity work, it may be of interest at this point to review the history of the development of the maternity service. In 1901 the Lying-in Hospital and the nursing association formed a plan of cooperation for the care of out-patients delivered by the Lying-in Hospital service. The obstetrical care given by externs of this hospital, who are Harvard Medical School students, has always been of high grade, and from the early days of the connection both the board and staff of the association have taken great pride and satisfaction in making the obstetrical nursing of equally high grade. As already mentioned, 26 per cent of the association's ma-

ternity service is for patients of this hospital. Work with the patients of the Jewish Women's Maternity Association, 3 per cent of the association's maternity service, is in cooperation with students from Tufts Medical School, who, under excellent supervision, deliver these patients.

Since 1912 there has been an extensive development of prenatal nursing by the association. Prenatal nursing care in Boston reaches, in proportion to the population, more mothers than are reached in any other large city in this country; and, so far as is known, there is no other city in which the percentage of mothers who come under care in the early months of pregnancy is so high. It is early care and constant supervision that insure good results.

Seventy-one per cent of the maternity service is, as has been said, with private doctors. About 600 private doctors, nearly all of whom include maternity cases in their practice, employ the nurses. Their cooperation and good will have an important bearing upon the service. They call upon the nurses because they have found these women an essential help in their practice; they have learned that the nurses observe the prevailing ethical standards of the profession, that they do not work without a doctor, and that public sentiment favors their employment.

The plan of work usually followed in the stations is to assign to each nurse a small area in which she undertakes the care of all the families. She is responsible for prenatal visits, for visits following the birth of a baby, and also for the care of any members of the family who become ill in the meantime. It is only through successful teaching, which secures uninterrupted good

nursing on the part of the family, that a nurse's hour at the bedside of a maternity patient, or half-hour spent in making a prenatal visit, will produce the best results.

TABLE 3.—*Prenatal and Postnatal Work of the Boston Instructive District Nursing Association, 1920*

Prenatal		Postnatal	
Number of cases	4,353	Number of cases (no prenatal care)	1,713
Number of visits	28,031	Infant mortality (under 2 weeks)	21.01 per 1,000 live births
Percentage of cases reported before the 5th month	6		
Percentage of cases reported before the 6th month	40	Stillbirths	39.11 per 1,000 births
Number of cases followed to conclusion	4,036	City infant mortality under 2 weeks	37.34 per 1,000 live births
Number of cases receiving postnatal care	2,834 (70%)		
Infant mortality (under 2 weeks)	13.37 per 1,000 live births		
Stillbirths	35.18 per 1,000 births		

Stillbirths showed an alarmingly higher rate in 1920 than in other years, a rate almost as high as that among the cases where no prenatal care was given. The one curious fact about this increase is that it occurred among the 30 per cent of cases to whom care was given during the prenatal period only, care at and after delivery being given in hospitals and by private nurses, attendants, midwives, and the family. Among the 70 per cent to whom the association gave care during both the prenatal and

the postnatal period, the stillbirth rate was even lower than in the preceding year. A total of 1,713 cases came to the association after delivery, patients who had not had prenatal care from any source. In the two preceding years there had been a startling difference in infant mortality and stillbirth rates between this group and the group that had prenatal care. In 1920 the infant mortality rate in the group having postnatal care was much less than that of the year before.

We may attribute the development of the maternity service to several factors. In part, it has been due to intentional emphasis of this branch of the work as one of the more important functions of the association, and in part it has been the result of circumstances. It has been fostered by cooperation with other agencies and by the extension of the confidence of the people in the work, evidenced in the constant increase in the number of maternity cases coming from private physicians. In the future development of the association this department will be recognized as deserving a considerable part of the working time of the staff.

Chronic Illness. Although the care of chronic patients is considered of less importance to the public health than the care of other patients, there is much to be said in defense of giving a good deal of time to them. In the first place, success of public health nurses in improving community health is dependent, to some extent at least, upon their popularity in any neighborhood; neither patients nor doctors will want the nurses if they refuse to render a needed service which they are able to give.

The problem of a bedridden paralytic may seem to concern only the patient, or only the patient and his

family; yet to the neighbors it may appear to be the duty of a public health nurse to spend a good deal of time with the patient. With the human need apparent and the sympathy of the community aroused, it would be a shortsighted policy that forbade the nursing association to care for that patient, even though life was not actually at stake.

The nurse, on her first visit to a chronic patient, tries to determine just what are his daily needs; whether or not he might be better cared for in some place other than his home; or what effect the illness, with its consequent upsetting of the household, is having, and is likely to have as time goes on, upon other members of the family. She uses all her resources in devising a plan which will best serve the interests of all. In many instances, some member of the family can readily learn to give the care necessary to the comfort of the patient, and when this is so the nurse need give only such time as is required to teach the "home nurse." In other instances, however, where the family burden is too great, the entire care of a helpless chronic patient should not be left to them; and then, if a "household nurse" cannot be provided, if removal to an institution is not indicated, and if no relative or friend can be found to assume the household duties, the public health nurse must take some responsibility for the actual care and relief of the patient, though his condition probably can never be improved. This course will best serve the cause she has at heart; for in meeting the need so plainly within her power to relieve, she will win new friends for her work and, through her relations with the family and the neighbors, she will find many opportunities for constructive health work which otherwise might not have been discovered. Chronic

patients will be a part of community health work so long as sympathy is an essential characteristic of a good nurse. During the past few years occupational therapy has produced remarkable results with many patients who, without it, would have remained in the chronically invalided, unproductive group.

Though in all services the association emphasizes teaching in the home, yet the nurses do not thrust themselves into the home to teach what is not desired. A public health nurse, trained to observe, to make a tactful approach, to establish friendly relations, and to render her visit profitable as a demonstration, will make her teaching unobtrusive and acceptable. Health teaching is a by-product of the nursing visit which calls for no apology but is made in response to an invitation, and this by-product is often of greater importance than the bedside nursing itself.

In connection with this subject of preventive work, it is of interest that in 177 cases of correctible defects which were under observation from January to June, 1921, the association nurses were successful in inducing 51 per cent to take treatment, although a study of these cases shows a large percentage—49—of uncooperative families. When we consider that such serious conditions as diseased hearts and infected joints may result from adenoids and infected and hypertrophied tonsils alone, the association seems justified in this effort. But study has shown that an arbitrary ruling must be made with regard to the number of preventive visits, for undoubtedly the nurses have often carried the responsibility in families for too long a period. It is now a rule in each station that six visits may be made to a patient where a physical defect needs correction. These visits must be

made in six successive weeks; for it is believed that after this period constant visits for the purpose of persuading patients to seek medical attention will not be productive of good results. If, by paying six visits per patient, nurses can save even 51 per cent of a given group from the serious consequences of neglect, they have made good use of their time. This is particularly true when we realize that the patients with correctible defects are, for the most part, children.

Table 4 shows the principal diseases or conditions receiving attention by the association in 1920, and the distribution of visits. Only ten diseases or conditions have been studied with regard to the number of visits paid, the selection being based on those requiring a large number of visits or for some other reason important in the service.

The simple division of the cases into groups as shown in the foregoing table leaves much to be desired, since it is impossible to differentiate the diseases in many instances. For example, a case of rheumatism, though usually chronic in character, often becomes acute; and maternity cases frequently develop complications, such as septicemia or albuminuric convulsions, which place them in the "acute" group. Yet in spite of these limitations, this classification into three categories serves a purpose, in that it indicates the character of the service and shows the place of emphasis.

With regard to specific diseases, an average of less than ten visits to a pneumonia patient will be noted. This appears to be a small number for this type of disease, but the figure is based on all the patients, including those who were nursed for a short time and then transferred to hospitals and the patients who had partial home

TABLE 4.—*Principal Diseases and Conditions of Patients Cared for and Discharged in Year 1920, Boston Instructive District Nursing Association*

Class of Service	No. of Cases	Percentage of Total Cases
Total number of cases discharged (not including 4,858 new-born babies)	26,233	100
I. Acute and communicable diseases	15,359	58.56
II. Chronic diseases	2,811	10.70
III. Puerperal state and well babies	7,976	30.4
IV. Not found or not requiring nursing care	87	.34

Disease or Condition	No. of Cases	Per Cent of Total Cases	No. of Visits	Average Visit per Case
Group I				
Typhoid fever	30	.11	312	10
Four communicable diseases of childhood*	1,797	6.85	10,516	5.8
Scarlet fever and diphtheria	105	.4		
Influenza	2,307	8.79	13,250	5.7
Diseases of eye and ear	547	2.08		
Bronchitis	1,303	4.97	8,528	6.5
Pneumonia	1,463	5.58	14,507	9.9
All other respiratory diseases	833	3.17		
Tonsillitis	1,151	4.39	6,040	5.2
Diseases of digestive system	1,673	6.38		
Acute diseases of the genito-urinary system	321	1.22		
Diseases of skin and cellular tissue	811	3.13		
Burns, fractures, sprains, wounds, and other external causes	946	3.6		
Encephalitis lethargica	2			
All other acute and communicable diseases	2,070	7.89		

* Includes measles, whooping cough, chicken pox, and mumps.

TABLE 4.—*Continued*

Disease or Condition	No. of Cases	Per Cent of Total Cases	No. of Visits	Average Visit per Case
Group II				
Tuberculosis	230	.88		
Cancer	257	.98	7,047	27.4
Rheumatism	282	1.07		
Rickets	78	.3		
Cerebral hemorrhage, apoplexy, paralysis	260	1	4,533	17.4
Chronic diseases of nervous system	288	1.09		
Diseases of heart	325	1.23	3,419	10.5
Diseases of veins	152	.58		
Other diseases of circulatory system	228	.87		
Chronic diseases of genito-urinary system	325	1.23		
All other chronic diseases	386	1.47		
Group III				
Pregnancy (with and without after-care)	4,353			
Maternity (without prenatal care)	1,713	23.12	64,447	
Other diseases and conditions of puerperal state	545	2.08		
Well babies	1,365	5.2		
Group IV				
Not found or not requiring care	87	.34		

care under a nurse's supervision. Actually, a number of patients had twice as many visits as the average. The average of twenty-seven visits for a cancer patient will also appear low; but this figure is affected in the same way as the pneumonia figure. It does not mean that the twenty-seven visits were made on twenty-seven consecutive days; in many instances it is not necessary to see these patients daily, and while many of them remain

under care for months, the nurse is often able to train some member of the family to give sufficient care to permit a lengthening of the interval between her visits.

With a view to determining how many persons needed but did not receive nursing help in 1920, a comparison of the association figures with statistics of morbidity was made. This showed that in any normal year about 40 per cent of the population are sick at some time. This figure includes mothers and babies in maternity cases, persons having acute illnesses, hopeless chronic cases, and all varieties of physical incapacity. Now, in the association service, only 5 per cent of these people were reached, that is, only one in eight. As many of the other sick persons were cared for by hospitals, institutions for chronic patients, or other nursing agencies, such as the tuberculosis nurses and the municipal nurses, the association nurses were not needed by all of them. Lack of coordination among the agencies for care of the sick in Boston rendered it impossible to know how many cases of sickness which should be cared for were not reached, but we do know that the proportion is relatively small.

The Board of Directors and Neighborhood Committees

The success of a public health nursing association depends in large measure on its board of directors, for this board determines the policies of the organization.

It is generally agreed that the board must be made up of people who are representative of the community,[4] that there should be both men and women members, that the

[4] The reader is referred to the files of *The Public Health Nurse*, 1927-28, for reports of the Lay Members Section of the National Organization of Public Health Nursing.

board should maintain a close relation with both state and city departments of health, and that it must, as a necessity of growth, develop local committees related to the central board in the most democratic form of organization possible to the locality. This plan of board organization has during the past ten years become the model upon which public health nursing associations are building.

Men are coming into administrative relations with public health nursing, but they can never take the place of women on the boards and committees. Health officials are, in a general way, forming the policy upon which the unofficial nursing associations work, and professional directors are being employed to conduct the association activities; but never in the history of public health nursing has it been so evident as it is today that the future success of the movement will depend very largely upon the continued interest of women such as have in the past controlled the work. Professional leadership is required, but it does not remove the need for the kind of leadership to be found in a lay board. We have sometimes seen the working methods, by which excellent results in community health were being secured, fall into disuse because, in turning over an unofficial piece of community health nursing to an official body, the women's committee had been eliminated and some head of a department of sanitation, communicable disease, or what-not had undertaken to control nursing policies and procedures.

In almost every community there is a great opportunity to organize the representative people into committees for the purpose of sharing in the administration of the work of the nursing association and aiding in its exten-

sion. There is a latent enthusiasm to be caught and, if possible, harnessed to the heavy slow-going vehicle of routine committees. If ten years ago a visiting nurse association required a president who was a natural leader, such a president is infinitely more needed today, when associations have many more patients and many more nurses. The development of committee work in an association can never be effectively accomplished by paid executives but always requires the leadership of those who are themselves private citizens trying to fit public duties into busy days which are already filled with many exacting details.

The board members of a modern public health nursing association are elected on much the same plan as they were in the past. In a general way, it was intended then, as today, to have representatives from the different religious faiths. But in the early days there was no other effort to make community representation a factor in selection. The emphasis was placed upon character, ability to raise money and readiness to do so, and upon faithful attendance at the regular meetings. Although today this does not seem to be a sufficiently broad basis of selection, we must remember that it is to committees composed of members chosen on this plan that we owe the vision that has foreseen the growth of the past ten or fifteen years and the devotion that has made that growth possible. It is important to recognize this vision and devotion, for they are qualities essential to the next steps in public health nursing, and in the process of standardizing the selection of members for community boards or committees we are in some danger of losing the old spirit.

The present-day board is a group of people having, probably, a greater interest in the principles of preventive

medicine and a greater knowledge of them than any other organized group in the community. It has a progressive outlook and a keen sense of responsibility. It recognizes that families whose income is good are as likely to spread communicable diseases as those of small income; that the protection of motherhood and infancy through public health nursing care must be extended to every mother needing it, no matter what her income; and that the teaching of mental hygiene may be required in families of every degree of prosperity. It knows that defects such as the crippled condition resulting from poliomyelitis cannot be corrected unless the community provides the means, and also that it is a matter that affects the entire community whether or not two hundred children are left to grow up cripples or are restored in the course of time through proper treatment. From the original impulse of pity and charity for the unfortunate we have come to a realization that necessary community work lies at our hand to be done and that such preventive work is of immense importance to modern civilization.

It is equally important to develop standard methods of administration for the board as for the staff of a public health nursing association. Nurses and executives of nursing groups must, of course, give a good deal of time to committee meetings, since this is almost the only means of contact between the association personnel and the committee members, or between nurses and other community workers. But from the organization of the board itself must come the enthusiasm inspired by a knowledge of the possibilities of a future health program through which an informed public opinion will grow and local support will come.

Up to about ten years ago not much attempt had been

made to separate the functions of the board, the staff, and the office force of a public health nursing association. Members of the board used to do many things which today only public health nurses are expected to do, and many of the present activities of a board were not carried out at all. For instance, in certain district nurse associations in the very early days each nurse was expected to report weekly upon the details of her work to some one member of the board who had been designated by the superintendent as her "manager," and it was expected that the nurse would conduct her work during the following week in accordance with the advice received at this conference. If the board member failed to appear at the appointed time the office agent, who was not a nurse, received the report. This plan has now been discontinued, and the professional direction of the work has been put entirely into the hands of public health nurses. The early procedure was of course disastrous to any unified direction of the nurse's work, but it has been mentioned here for two reasons: first, because the contrast is so great between present and past methods; second, because the old way served the good purpose of bringing the reality and the intense human interest of the daily work close to the minds and hearts of the board members, which is the most difficult task before the president of a visiting nurse board of today.

Board Meetings. The board members, usually a body of some thirty people, must be given every possible means to learn the vital interests of the association. The regular board meetings, which as a rule are held once a month, afford the opportunity for this. In a group of thirty there are always some people not active in association committee work, and for them the regular meeting

may be the best means of making the work vivid and real. The meeting must be well managed and thoroughly alive if it is to serve this important purpose. The plan of a meeting is somewhat as follows: after it has been called to order, the executive officers join the group. Then follow the reading of the minutes, reports by the chairmen of the various committees, reports of the treasurer and the director, and lastly the recommendations of the executive committee for consideration by the board. The program of the association must be presented each month in such a manner that the members will go away not only informed and interested, but greatly stirred to work for a cause they care much about.

Each active committee will be eager for an opportunity to inform the board of its own particular interests and the director will seek the same opportunity, so if the meeting is to be a success the time to be allotted to each subject must be carefully planned. The report of the director is not an easy one to make because this officer is working closely with all committees of the board from day to day, and therefore what she says at board meetings will be a repetition of what the other officers and the executive committee may have heard several times before, each person present perhaps being familiar with some part of it. Such a report may very well begin with a concise statement of the work of the month.

The president carries the responsibility of the meeting, seeking to stimulate discussion on all important subjects and to create in the minds of the board members that faith in the cause and devotion to its interests without which there can be little hope of reaching the community. Her greatest task is to cultivate the latent force

and power which may be present in a board. Compassion and sympathy are still very close to the service of today, as any executive knows who has tried at a board meeting to draw a picture of a new and particularly urgent need.

Almost every community activity affects public health nursing and is affected by it, so that much of the time of paid executives of the association must be taken up with the duty of representing the association, or rather the cause of public health nursing, as members of committees of various kinds in city, county, and state. The association work profits very much by this representation and suffers when such a policy is not followed. The director's reports at board meetings must contain an account of these allied activities. Sometimes one hears a new board member question the practical wisdom of introducing so wide a range of subjects, but as new members learn more of the actual work of the nurses and of the place they hold in other community work, they come to realize that a public health nursing association cannot escape sharing the responsibility for those social conditions which cause sickness. The report of allied work may be concerned with a mayor's committee on housing, with plans for a community chest, for a health league, for federal legislation for the protection of motherhood and infancy, or with the educational aspects of public health nursing.

For a detailed discussion of the activities of a public health nursing association board, the reader is referred to Mary S. Gardner's book, *Public Health Nursing.* I have selected for consideration in the following paragraphs two or three of the committees more recently introduced by public health nursing association boards;

I shall not touch at all upon other essential committees, since their functions are generally understood and accepted.

Board Committees. The activities of the board of a public health nursing association are concerned with the raising of money, the voting of policies for its expenditure, and the securing of adequate legislation for the furtherance of these policies. These functions are fulfilled with the aid of three committees, namely, a publicity committee, an extension committee, and a committee on legislation.

Publicity. The members of the nursing staff may be moved by some need of the community, but their emotion is of small service unless the board feels it too. The board may be burdened with the realization that lives are lost in childbirth through an insufficiency of maternity nurses, but this profits little unless the community recognizes the seriousness of the situation. A means to spread abroad the knowledge possessed by the board and the staff nurses must be found. The function of publicity or educational propaganda therefore becomes of first importance to the work.

A publicity committee is to be found in most boards. This committee formulates a plan for bringing the needs of the association before the public and estimates the cost of carrying out this plan. If the board accepts this broad general program, and with it the budget for publicity expenditure, the plan becomes a guide for the coming year.

In many associations publicity is considered of sufficient importance to require a full- or part-time secretary. This employee attends to newspaper publicity and prepares bulletins, descriptive leaflets, and a regular monthly

summary of the work of the association based on an analysis of the records supplied by the registrar. All plans of the publicity committee are made to lead up to the yearly campaign for money raising, a period of great activity for the publicity secretary.

Publicity must begin with the board members and must be extended by each one of them to the members of his or her own circle of friends. When the board is really representative of the community, this means an important dissemination of interest in the work. Among the thirty or so board members there will certainly be found some whose friends include the principal doctors in town, and yet it is rather generally true that well-known and successful doctors have little understanding of what the public health nursing association is doing or of the results of its work. The mayor and council, too, ought to know much more than they do about privately controlled public health nursing, and they also can be reached through a definite intention to inform them. A little effort would enlist the enthusiastic interest of these influential men. In this kind of "private publicity" a good plan might be to have the committee on publicity arrange dinners at which talks would be given on special subjects. When no specific demand is made upon the time of the guests afterwards, such dinners are very pleasant and also valuable to the cause. The association executives will be a help in making the occasion one of interest to the guests.

The Extension Committee. For a public health nursing association to include a committee for the extension of the work is a recognition of the principle that unless a local community wants public health nursing and will work to help maintain it locally, a central committee

ought not to introduce it. Acceptance of this democratic principle carries with it a recognition of another even more significant, namely, that local neighborhood representation is essential on a modern board of a public health nursing association. Sound policies cannot be formulated without such neighborhood representation in the central body, nor can the budget be raised without local help. The demand for more stations in one part of town after another brings out clearly the necessity for taking into account these principles of organization.

So rapid has been the demand for expansion of public health nursing into new localities that it is almost more than a committee on extension work can accomplish to be ready with new neighborhood committees as the calls from district after district make the establishment of new centers imperative. The task requires a great deal of patience and tact, not to mention the enthusiasm necessary to lead others to believe in a cause about which they are only beginning to be informed. And much time is required for the many social calls necessary to secure the nucleus for the first committee meetings. It is important that the members of a local committee be representative of the neighborhood and that they include both men and women. After the new committee is established, leadership is needed. The board member who is organizing the committee must be present at all its early meetings. General policies cannot of course be altered by local committees, but in other respects the monthly meetings of local committees are not unlike board meetings.

There are many ways to keep a local committee alive and interested, the most obvious being central representa-

tion and, through this, the pooling of interests. Each local chairman and supervising nurse together devise ways of bringing committees and nurses into contact. In addition to the regular monthly meetings in stations, all chairmen of local committees may meet once a month with the extension committee of the board when, perhaps, the director of the association may be present. Suggestions for the development of the station committees come from the extension committee to the local committees, and from directors to supervising nurses; but each station is a little different from every other, and the committees vary too.

Committee on Legislation. The third of the three committees of the board, the committee on legislation, must be active at the time of legislative sessions and alert at all times to keep the board informed of bills coming before Congress or the state legislature which would affect public health nursing interests. An illustration may make the work of the legislative committee clear. An ordinance concerning state registration of nurses had for several years been a handicap to nursing interests in a certain state. As it stood, any woman might take a state examination and, if she passed, become a registered nurse whether or not she had ever had any training or experience in the care of the sick. Under such an act many of the best prepared nurses did not wish to register, while women who had perhaps failed for some good reason to pass a course of training for nurses often took the state examination and became registered "nurses" in the state. So many other issues were involved besides the standing of professional nurses and the protection of the public from the danger of being nursed by un-

trained women, that for some years this pernicious law remained in operation, and repeated attempts to introduce a better one were frustrated. The opinion of the nurses had little weight against the opposition of inferior small hospitals whose interests ran counter to any standard hospital training for the young women who, after finishing their time in training in such hospitals, would wish to become registered nurses in the state.

This law was selected by the association as one upon which its legislative committee ought to work. As a first step the committee conferred with the state nurses' association and a joint committee was formed from the two organizations. It was evident that the strongest argument for bringing in a new bill was the protection of the public from inadequate nursing care and, therefore, that nurses, who were accused of wishing above everything to advance their own prestige and secure for themselves a better position, were not the people to work most effectively for it. The plan of campaign determined upon was a simple and successful one. The boards of all the visiting nurse associations throughout the state were appealed to by the committee. This was comparatively easy, because there is an organization of directors of visiting nurse associations in the state under discussion. Each association was asked to give the question of a bill for the registration of nurses careful consideration and, if it approved a change in the existing law, to delegate members to see personally the senator and representatives for that locality and to send return postal cards stating the result. Cards printed as follows were supplied:

I have (or have not) seen Senator .....
He approves (or does not approve) Bill .....

It was an exacting task to follow up every association and get information from every locality, but the new bill became a law and it was said by members of the legislative committee at the statehouse that not for a long time had any bill caused so much interest throughout the state as this one.

In the work of each of these three important committees of the board—extension, publicity, legislation—the paid officers can help very much, but they cannot, in the very nature of the work, do it by themselves. The success of these committees is dependent upon volunteer workers.

The Nursing Staff

In defining the present-day standard of selection for public health nurses, I should like to begin by saying that they all should be graduates of a course in public health nursing; but our schools for public health nurses have not been able to meet, even approximately, the demand for graduates. Since there are but eleven courses in public health nursing in the United States [5] and approximately 12,000 public health nurses working in many organizations in every state in the Union, other methods of standardizing the preparation for staff work are necessary. The one most generally adopted is the teaching course centrally conducted or a unit of instruction covering classes, conferences, demonstrations, and progressively planned field work with intensive supervision.

We must keep our vision clear on two points, namely,

[5] Endorsed by Education Committee, National Organization of Public Health Nursing (1928).

that the nurse in public health is a necessity and that it is impossible to get enough nurses to do the required work. Our evident duty then, if we are to have our citizens as vigorously well as is within our power, is to make the available number of nurses in public health go just as far as possible.

Looking back ten years and comparing a public health nursing staff of that day with a staff of today, we are inclined to believe that there has been a most striking development in the outlook of the workers. A modern public health nursing staff, seen in a group, will make an unfailing impression of alert mentality and will convince an observer that its members have gained a knowledge of certain of the real experiences of life and that this knowledge has developed a kindly appreciation of, and an affection for, the general run of people.

The public health nurse of the present time knows that if she is to be successful she must come close to the families under her care in many ways besides through the physical contact of bedside care; and even though bedside care may not be included in her program she can establish intimate relationships. When experience has taught a nurse that in her efforts to be of assistance to another person it is her individual character alone that mars or saves a situation, she acquires a quality that can best be described by the word "mellow." She has learned that only by helping people to help themselves can she serve them. There is also a sense of belonging to something much bigger than herself, of having an important part in a great undertaking, and of confidence in the ultimate result of the daily routine, even though the day may have been filled with discouragement and the distress of individual tragedy. Such an outlook is largely

the product of the ten years just past, for it is during these years that public health nurses have been able to collect data and publish statistics showing the direct effect of their visits upon community health.

In their own experience the staff nurses have lived out the principle which is the root of all success in their work. They believe in the dignity and value of their daily lives, knowing that they are a part of a great constructive force which must in the end correct much that is unbearable in the relations of people to one another in our present social structure. In so far as they are able to create a similar faith in those with whom they come into intimate relations in their visits, they may be successful in bringing health to the families intrusted to them. For instance, teaching the laws of the hygiene of maternity in a family in which discouragement with life has been so great as to almost produce despair at the prospect of another baby, could never, in itself, reduce the baby death rate one-third.[6] Observation makes us confident that these results are due, much more, to the ability of the nurse to bring back to the mother a belief in the possibility of controlling the conditions of her life, a belief in the dignity and happiness of motherhood.

Of course, ten years ago there were many public health nurses who were inspired with this essential spirit and who were doing good health work every day. The great difference between the nursing services of that day and of the present lies in the development of an organization planned to foster and to produce in the staff that unity of purpose which comes from recognition by the whole group of the reasons for the adoption of associa-

[6] "The Beneficial Results of Prenatal Work," by Michael M. Davis, Jr., *The Boston Medical and Surgical Journal,* (January 4, 1914.)

tion policies and of the results obtained through these policies and routine methods of work. This principle of organization has been expressed in the phrase "the clearly defined ideal." Development of administrative methods during these ten years has been largely influenced by a recognition that the nurses themselves are the best judges of the policies which are to govern their work. In certain associations, policy, working technic, and administrative routine have all been developed by board and staff together. Staff conferences and supervisors' meetings, taking place weekly, give opportunity for full discussion, criticism, and suggestion. The directors do not recommend any important change to the board until it has been considered at these meetings and approved by the staff.

A weekly staff conference to which anyone belonging to the nursing association is welcome, and to which all staff and student nurses are expected to come, is customary with some associations. If there is a school of public health nursing in the community the faculty may attend the meetings. The chairman of the nursing committee may also be a regular attendant. The meeting may be in the charge of a program committee made up of staff nurses and of students if there are such. Subjects for the conference are chosen by the committee and the discussion is conducted by its chairman. The subjects relate directly to the daily work of the stations or to closely allied subjects. Four subjects are given to show how varied the conferences may be:

1. Should visiting nurses care for patients with communicable diseases while they are nursing other cases of illness and making preventive visits?
2. The collection of fees.

3. The association budget for this year and how the board is trying to raise it.
4. Mental hygiene in the homes visited.

Sometimes the program committee invites a speaker to talk on some important subject; sometimes the conference is given up to discussion, and the committee is pleased when differences of opinion come out in friendly debate. The conference affords, moreover, an opportunity for the executive officers to bring before the staff information about public health work other than their own, comparative statistics, and questions or criticism of any kind. Certain standing committees may report at the conference.

In one association a publications committee composed of two members of the staff and one of the nursing committee proved to be of value. Its object was to keep the members of the staff informed of new books, magazine articles, and health publications in general and to stimulate them to keep up their reading. This was done by suggestions for the practical arrangement of books and magazines in the stations and by bringing to the conference abstracts of articles of especial interest appearing in the current magazines. Some of the local committees were interested through this committee to subscribe for magazines for their local stations. More than thirty copies of a current publication were purchased by staff nurses following the reading of a review of the book at a staff conference. It is not easy to keep alive an active interest in technical reading in a group of public health nurses, whose time is so fully occupied with practical duties. Success must ultimately depend upon the individual station supervisor.

The weekly supervisors' meeting is common in many

associations, and its character is usually informal. The chairman of the nursing committee may attend this meeting also, and when there is a school the presence of members of the faculty is valuable. One of the executive nurses may arrange the order of discussion, which may follow reports from the stations. These may fall under certain main headings, such as policy, legal problems with families, social problems, technic or other routine. There may be also reports of the activities of local committees. The affairs of the week and its difficult situations are discussed; thus the experience of each station becomes common property and gradually there grows up a uniform method of dealing with most of the family problems that confront public health nurses. Standards for public health nursing procedures built up in this way are pretty sure to be sound because the growth is both democratic and slow. Matters of technic or other routine may be left to committees of the staff to work out and submit for ratification at supervisors' or staff conferences. Technic is revised in this way, regulations for the stations altered, and uniformity in station routine secured.

A more recent development than the full staff conference or the regular supervisors' meeting is the staff council which has been established in several of our larger cities. This council is an outgrowth of the self-government ideal. Each local section elects a delegate to the council, and the delegates come to the meetings empowered to act for their local groups upon all matters. Questions concerning uniforms, hours, details of equipment, policy, matters of discipline, are brought before the council and receive serious consideration before recom-

mendations are made and passed on to the supervisors' group and the nursing committee in case further action on them is needed.

The modern tendency in committee administration is thus to divide first into small local groups and then to assemble in central bodies in order to secure unity of action. This principle is important both to board and staff. The pooling of experience through bringing together local committees is of as much value to the board as is the pooling of station experience to the nurses. There seems to be only one safeguard necessary to both staff and local committees, and that is to be sure that new ideas arising among the nurses of a station or among the members of a local committee are brought to the central administration to be acted upon there. No change in policy or administration can be initiated locally.

Until one has seen the effect upon the character and methods of the regular nursing visits of a well-conducted weekly staff conference, it is difficult to realize how much may be done, through the conference, to unify the service of a large staff. It is of the utmost importance to devote time and thought to the purposes to be served by each nursing visit and also to methods of maintaining staff interest, enthusiasm, and breadth of outlook. Details in relation to staff administration that are important to maintaining staff efficiency, are salaries, vacation, sick leave, and promotion. These are matters that ought to be made the constant consideration of a committee of the administrative board because conditions make it necessary constantly to revise decisions about them. Changes are to be expected in any work that is alive; they should not come about through arbitrary decision of the board or of the executives, how-

ever, but should result from continuous study of staff needs by both committee and staff.

Some Points to be Considered

When all the facts concerning public health nursing administration lie before us and we try to piece out from them our vision of the future and to fit them into that present pattern which we hope will produce the desired result, we realize all too well that there are facts which are not clearly related to other facts and principles not yet adapted to meet the growing demands of the public for a practice of health protection far removed from much of the present-day practice of medicine. These considerations affect profoundly the future of the nurse in public health.

When a community of prosperous persons of moderate means demands, supports, and makes constant use of a baby clinic where an expert in baby care and trained public health nurses are available, how much ought the parents to pay for the service? Physical examinations and direction of the health of well people are being demanded by an enlightened public. What of the tradition that no charge must ever be made for the services of the department of health? Is it tenable under the new conditions? We profit far more from advantages for which we pay. Voluntary health agencies have found in a long and extensive experience that a service is more effective when it is paid for. It would not be inconsistent for a department of health to make a cost charge for health services in homes of the community. This is done in the case of patients in city hospitals.

And what of the private doctors practicing old-fashioned medicine? When mothers take well babies to these doctors, they usually do not get the expert teaching they need, and they know that they do not get it. Who will bring the private doctor into the field of preventive medicine as it is related to the activities of public health nurses? Will departments of health lead in this movement? Surely the time is coming when young medical men will graduate with a knowledge that will lead them to introduce into their private practice just those activities undertaken by so-called health agencies today.

Another question to be considered is how the problem of health protection can best be met. That every public health nurse should perform in each home all of the health services that are offered by the association with which she works was found by the Committee for the Study of Nursing Education[7] to be the most effective method of health teaching, and also that teaching the care of the sick may without consequent loss be a part of a nursing visit. Miss Goldmark, secretary of the committee, says, "Again and again in our study, the principle that curative care provides an approach to the preventive has been illustrated. Gratitude for relief in suffering or for the relief of those who are dear is a potent motive in opening the minds as well as the hearts of men." It is well known that "one-sixth of the total number of nurses are doing one-fifth of the work" under the plan of completely generalizing the service.

Shall we, perhaps, in a not very distant future, unite all necessary types of public health nursing in a generalized system under a department of public health, com-

[7] *Nursing and Nursing Education in the United States,* The Macmillan Co. (New York, 1923).

bining the service of private practitioners with that of full-time public health officers? Shall we not make of the boards of our voluntary health agencies, themselves coordinated into one group, a committee of citizens in an advisory relation to the chief of our official health department? Then all the workers would be under one leadership, developing one plan, and working with harmony and without rivalry, under one standard of service. Contract services with insurance companies and other kinds of health work of an experimental nature could be undertaken by the committee, the time of all workers—overhead and otherwise—being paid for by departments of health or by the committee, on a "unit of time" basis, but each worker doing all required in each home whether as an agent of the department of health or of the committee. All publicity and educational propaganda of the committee would be directed toward popularizing the official health body. Local committees would become advisory committees for the common group of local workers. Surely with this procedure the public would be less confused, and the community would profit by a more intelligent understanding of the aims of the unified program. In each local center perhaps there would be representatives of the various "social" agencies who would correlate the activities of the many hospital social service departments, family relief, and children's agencies. For with the many well-meaning workers whom we have in every neighborhood, the machinery for cooperation becomes so complicated that it sometimes fails of its purpose, and there are times when it is never set in motion at all.

CHAPTER IV

PUBLIC HEALTH NURSING IN EUROPE

THE nurse in public health, in one form or another, is to be found in almost every land. It is not possible to review in the present volume the history and development of public health nursing in all the countries where it exists,[1] but neither is it possible to leave out all mention of those newer and vital public health nursing organizations which are already well established in certain of the old countries. These agencies, we believe, will profit by the mistakes we Americans have made and thus, by taking a short cut, may arrive at a better preparation of personnel for public health nursing and better methods of organizing and administering this work than we have as yet achieved. The pictures here presented are not selected for any reason other than that the memory of each comes readily and vividly to mind as I write.

I will carry always in the back of my mind, or the bottom of my heart, a picture of a great ward in one of the old countries where I was once taken "just to see what a hospital without nursing is like." It is in a great hall of lovely proportions, once part of an ancient

[1] For information on the development of public health nursing in foreign countries the reader is referred to *Public Health Nursing,* by M. S. Gardner, the Macmillan Company (1924); *A History of Nursing,* by M. A. Nutting and L. L. Dock, G. P. Putnam's Sons (New York, 4 vol., 1907-1912); *A Short History of Nursing,* by L. L. Dock and I. M. Stewart, G. P. Putnam's Sons (New York, 1925).

monastery or abbey, with Gothic windows high up in the thick stone walls, and rows of beds, thirty or forty of them, on either side. Lank cats skulk under the beds for the scraps of food the patients have stuffed into their bedside tables. Screens are unknown, privacy has never been thought of as adding to the patients' comfort, nor has cleanliness or order been considered in this connection. The odors are fearful and unforgettable. The men and women who attend the poor patients in their dreadfully uncomfortable beds are a degraded group. Passing down the stone corridor outside the ward we reached a great counter within an arched doorway. Two printed signs are hung here announcing that bread and wine are distributed through the opening. One sees the great loaves sent out to the wards in picturesque wicker baskets, and the wine, red or white, in its bottles. Just so must the monks have distributed them years and years ago. In contrast, vigorous new examples of hospital nursing and of community nursing in connection with programs of public health stimulated and delighted me and, always as I observed these developments in the old countries, that picture of the conditions of a past which still persists helped to give me sympathy and understanding.

France

In 1922 the French Government adopted a law which is framed to regulate the practice of nursing and which implies regular government inspection of the centers where nurses are educated. A board composed in part of nurses carries on this work of inspection and registration.

Social Service in Paris. Under an inspired leader carefully educated for her task, the social service work in the Paris clinics has now developed to include twenty-four centers with a corps of more than forty health workers, each eligible for state registration as a nurse in France. Nowhere have I seen a finer spirit or a more exalted idealism applied to community health nursing. Not under any conditions, even in highly developed fields of social service in the United States, have I observed finer individual case work. I remember particularly the skill with which a young member of the staff dealt with a suspected case of venereal disease in a girl who had come to the clinic. Nothing could be more human and at the same time more professional and efficient than her approach to this patient and her method of conducting the case. This service is an example of the best that can be accomplished by preventive medicine linked to social service through the work of the public health nurse who is also a trained social worker.

Bordeaux. The Florence Nightingale School of Bordeaux is in the outskirts of the city, in a lovely French garden where nightingales sing at sunset. Visited on the occasion of the opening of the American Nurses Memorial Building, which was dedicated to their sister nurses of France in memory of American nurses who died in the World War, it seemed to embody the spirit of its noble and devoted founder, Dr. Anna Hamilton. Such vitality, gaiety, and charm as the young French student nurses showed that day would be hard to match. They danced with most delightful effects of light and color, they sang in the darkening garden, they gave a little play indoors. Surely France has a great treasury of

youth and vigor and idealism to draw upon for the nurses of the future.

Lyon. In this French city of about 600,000 inhabitants there is a young school of nursing where we found an interesting adaptation of old methods, traditions, environment, and even personnel, to the ideas of a new age. The school is under the patronage of the University of Lyon and is affiliated with the official Department of Public Health. There is a school committee, with the dean of the Faculty of Medicine as chairman.

The nursing course in this school covers a period of two years. The civil hospitals of Lyon, of which there are eight, with 5,000 beds in all, provide the clinical field for the student nurse. Public health nursing has an important place in the curriculum, and field work is found for the students in the clinics and through home visiting in connection with them.

Long ago, at a time when the people of Lyon were dying by hundreds of the plague, an order of religious sisters was created for the sole purpose of nursing the sick in the civil hospitals. Members of this oldest order of nurses in the world still staff the wards of the hospitals of the city. They are not as closely restricted as the members of other nursing orders, and many are to be seen outside the hospital enclosures, going freely about their business in the city like other citizens. Of the many interesting features of the school perhaps the most striking is the plan, instituted more than two years ago, of sending six of the religious sisters away for postgraduate nursing work for a period of twelve months so that they may return prepared to become supervisors in the units of the civil hospitals from which they came.

The lay pupils of the school come with good educational background and from families of excellent standing, a sound basis, even though the numbers are small, for building up the profession of nonreligious nursing. In the Charity Hospital the sisters conduct a school for midwives. There is a head sister who has occupied her post for thirty-two years, and a permanent staff of fourteen assistants. Members of the staff of the Faculty of Medicine of the university give lectures to the student midwives, and the sisters give instruction in the nursing care of the patients. The school stands high in the quality and spirit of its work, and the sisters maintain a delightful atmosphere throughout the wards.

It is necessary to visit the Lyon school to appreciate its remarkable plan for adapting the old to the new and at the same time of preserving the best of each. The court of entrance, Cour Ste. Marie, at the Charity Hospital and the court tower of St. Vincent de Paul give the setting and atmosphere of the school. On the ancient balcony, Galerie de la Salle Ste. Renée, patients from the children's ward are placed on small wooden shelves, for sun and air. One cannot reproduce in words either the atmosphere or the setting, but nevertheless one is strongly moved on entering this lovely old place. I once experienced the same emotion in an ancient monastery in Italy, to which, I was told, the old nurse who cared for Dante's Beatrice had besought of her master the privilege of bringing the sick poor in order to care for them. Tiny gardens with a shrine and a fountain in the center are found in courts and cloisters, much as they must have existed for centuries; and the spirit of the place is almost tangible.

Within the charming old buildings has been found space for modern recreation rooms, a demonstration hall, classrooms, and living quarters. Lunch was served in the refectory by the sisters. Such a delicious luncheon, such gracious hostesses, such a cloud of memories of past years when others had been served by this order of sisters at this very refectory table and from these very benches! Best of all was the historic library into which we entered through a door of fitting design and workmanship to guard the treasures on those shelves. We visited the pharmacy too, with its priceless blue and white jars contrasting with the carved woodwork colored almost black by the centuries. A modern nursing school must absorb something when housed in such a place.

Avion, Sens, Pas-de-Calais. An organized effort to introduce public health nursing to a mining district of France may be observed by paying a visit to Avion. Here, in 1925, a population of 15,000, including 1,800 schoolchildren, was served from a health center where there were two *visiteuses d'hygiène* (public health nurses), two *sages femmes* (midwives), and four doctors. Baby clinics were held, and schoolchildren were received at the center if the teacher requested it. Visits were made to the schools by the *visiteuses d'hygiène.* The introduction of home visiting on any large organized plan must always present added difficulties in a country where the privacy of the home is protected so consistently as it is in France. In such centers as this, where the management of the mines has an interest in the health of the workers, organized home visiting may be more readily assimilated.

Poland

The University of Cracow, one of the oldest in Europe, has established a school of nursing. Here training in public health nursing is made an important feature throughout the two-year course, for Poland must have public health nurses to carry out her extensive public health program. She already has many of these and must have more. The national Department of Public Health has associated itself with the university in the development of the school of nursing, a combined interest which makes for permanence and healthy growth. The nurses composing the faculty of this school have been years preparing for their work. One instructor on the staff has spent seven years in such preparation, the last one of which was devoted almost exclusively to public health nursing.

There is a spirit in this wonderful old university which is felt by the visitor the moment she steps inside its gates. The university library is the identical room in which, in other days, the great Copernicus came to read and study. The visitor may see a parchment scroll on which his signature appears among those of his classmates. Perhaps it was from the Renaissance cloister itself, into which the visitor has just stepped, that the young Copernicus looked forth into the blue night at those bright stars above him and learned the laws of the planetary system upon which our modern science is built. Astronomer, doctor, painter—born in 1473, dying in 1543—he has left an inheritance to these latest students, the young women who enroll in the nurses' school and live in the university building made over to them.

Yugoslavia, Kingdom of the Serbs, Croats, and Slovenes

In this new nation the growth of a new profession is particularly fascinating to study. A vigorous, intelligent people has awakened to a period of intensive growth and to a self-conscious valuation of its resources and its need to develop those resources. It is taking vital hold of the extensive health program the government is providing. The Minister of Health has promoted the development of local health centers which must be staffed with doctors and public health nurses for clinics and home visiting.

A new school of nursing has been established in connection with the State Hospital in Zagreb. Here public health nurses are being trained and courses in the theory and practice of nursing are being given to sisters of the religious nursing orders. Before the opening of the school all the nursing care in the hospitals of Zagreb was given by the nuns. At the university clinics, which have 340 beds in all, there were 22 nuns in charge of the housekeeping and administration, and 49 assigned to nursing duty, a ratio of about one nun to seven patients. In the State Hospital the ratio was about one nun to ten patients.

In a country where until recently there have been no nurses apart from the religious nursing orders, a long process of education with much propaganda has been required to persuade young women to enter nursing, and to promote the development of methods of organization and administration for the public health nursing group. The new school for nurses was organized by the local

Minister of Hygiene in 1921 and is supported entirely by the state. A remarkably efficient nurse, graduate of the excellent school of the Rudolfinerhaus, Vienna, was made directress. At the time she took charge, five students, two of whom were nuns, were sent away on government scholarships, to study nursing in Vienna. The nuns completed their studies, were given the nurses' certificate, and became sister tutors in the school. They supervise the bedside work of the student nurses in the wards of the State Hospital and the university clinics.

The plan of organization of the school included five hundred hours of class instruction. The first class spent only fourteen months in taking the course, but the time has now been lengthened to two years. The state pays student nurses a stipend during their training. Thirty-four nuns and eight lay nurses graduated in the first class of the school.

To get a complete picture of this nursing school we must go first to the group of buildings, some of which are converted German barracks, where the nurses live and classes are held. They are on a grassy knoll adjoining buildings which house certain activities of the Sanitary Department. Visitors who partake of the delicious lunch cooked and served by student nurses, and who are charmed with the spontaneity and sweetness of the chorus singing of the students during dessert will not soon forget that impression.

A part of the bedside training is carried on in a building more than one hundred twenty years old. Everything shocking in personal care, or personal neglect, of the patients might well have been expected under such handicaps as one saw in these wards. But in spite of almost no plumbing, no ventilation in a modern sense,

no proper kitchen and serving quarters, we found here cleanliness, order, comfort, and consideration of the patients to a marked degree. It showed us what an ideal of nursing care combined with patience and vigilance can produce under the most difficult conditions.

But what, one asks, are these young women capable of doing after the course is completed? However great the respect we had acquired for the initiative and spirit behind this beginning, we felt that we could not expect much from a recent graduate of so young a movement. To satisfy ourselves on this point we took a long motor drive beyond the city of Zagreb for the purpose of visiting several of the health stations established in rural communities, because it is here that one finds the newly graduated public health nurse. These health stations combine child welfare centers with general dispensary activities and an emergency receiving station. Established by the American Commission under Dr. Reeder, they have been taken over by a peasant association known as the Zadruga, which has the protection of the Ministry of Social Hygiene and is a very interesting attempt at fixing local responsibility for health and education. The public health nurse, or health worker, has her desk and records in the station. From there she visits the people of her area, teaching them, as well as she is able, the lines they must follow in the program for which she is responsible. The official concern of the Ministry of Hygiene is with child welfare, tuberculosis, venereal diseases, trachoma, and malaria.

I accompanied a public health nurse to the charming home of a Croatian peasant. I bent my head a little to enter. Just one inclusive room served all family needs. In one corner was a tiled stove, in another the family

dinner table surrounded by its built-in benches. Also built into the structure of this "house-place" was the bed on which arose one soft feather bed on top of another until steps were needed to climb up into it. Dark wooden beams barred the ceiling of the room and in the very center of these we saw the Christian symbol, I.H.S. The relation of our Croatian public health nurse to the family in this home was much like that of a good public health nurse anywhere.

Each Croatian family makes extensive use of a certain wooden trough or trencher, which is hollowed out of a tree trunk and has rough handles and a curved bottom on which it rocks like a cradle. It is used as a pan in which to make the bread; the baby is put to sleep in it; soiled clothes are taken in it to the brook for washing; filled with heavy stones and rolled along the table, it is used to mangle the same clothes when they are clean. One lesson that the public health nurse is teaching her people is that, for the several purposes, several trenchers are needed! She is making genuine public health nursing visits, and the mothers are learning from her many valuable things.

CHAPTER V

MATERNAL CARE IN ENGLAND AND DENMARK

A DISTINGUISHED professor of obstetrics used always to begin the opening lecture of his course in this way: "Gentlemen, parturition is a normal process, alike in the cow and in the countess." He began with the central truth from which the science of obstetrics has grown. Childbirth is a normal process, and the task of keeping it normal and promoting those conditions necessary to doing so has occupied the attention of doctors, midwives, and nurses for generations. Who is the best attendant for the mother during this period, when, though the physical process is normal, every ounce of her strength will be required, every bit of her courage will be needed, and it will be essential to help her to maintain a calm and quiet attitude of mind in order that she may go safely through an ordeal, the severity of which seems greater and more demanding the more one studies it? From the earliest days women have been employed to act as attendants when a child is born.

The high watermark of ancient obstetrics[1] was reached at the time of the great Alexandrian School, of which one of the most distinguished members was Soranus of Ephesus. The famous treatise of Soranus

[1] The following brief summary of the development of obstetrics is based on a preliminary chapter of *Gynæcology with Obstetrics*, a textbook for students and practitioners, by John S. Fairbairn, Professor of Obstetrics, St. Thomas's Hospital, London.

on midwifery and diseases of women was hardly more than a statement of the methods of the Alexandrian School; nevertheless, it led the practice of obstetrics for nearly seventeen hundred years, until the time of William Smellie, who was born in Scotland in 1697 only twenty-one years after the publication of the English edition of a famous old book called *The Byrthe of Man Kynde.* The history of this book was as follows:

It was written by Röslin, a German, and through a play upon his name, was called when it first appeared *The Garden of Roses for Pregnant Women.* Translated into Latin and afterwards into English, Dutch, French, and Italian, it became, with many alterations and emendations, *The Birth of Man-Kinde.* There were seven or eight German editions and twenty-eight Dutch, the last appearing in 1742.

During the Dark Ages, medicine would have died had it not been for two Arabian physicians. Italy developed schools of medicine after the Renaissance; and it was in these Italian schools that William Harvey and his great friend, Willoughby (1578-1655), studied. Dr. Willoughby says of the duty of a midwife:

> The midwife's duty, in a natural birth, is no more but to attend and wait on Nature, and to receive the child, and (if need require) to help fetch the after-birth, and her best care will be to see that the woman and child be fittingly and decently ordered with necessary conveniences, and let midwives know that they be Nature's servants. Let them always remember that gentle proceedings (with moderate warm keeping, and having their endeavors dulcified with sweet words) will best ease and soonest deliver their labouring women.

In 1663 Louis XIV employed a surgeon for the confinement of a favorite mistress, who believed that she

could keep her secret better if no women were present. This surgeon, Jules Clement, was so skillful that it became the fashion at court to employ him; and at this time the word "accoucheur" was coined to describe the surgeon who undertook deliveries. At about the same time, the Chamberlens, father and three sons, Englishmen, invented the obstetric forceps. These men would be entitled to a distinguished place in the history of maternal care had they not become mercenary and attempted to keep their secret from the world or to sell it to the highest bidder. The invention of the forceps revolutionized maternal care, even though the development of its use was retarded by the unworthy attitude of those who invented it.

Only men could use the forceps, and therefore men at childbirth began to be associated with terrible and gruesome operations. Men had been brought into confinement cases only under these horrible conditions; men were associated in the minds of the people with agony and death, and therefore there was a prolonged struggle to keep midwifery in the hands of women only.

In England, modern midwifery may be said to have begun with Smellie. Since about 1667, both doctors (chiefly men) and women (chiefly midwives) have been employed in giving maternal care. One finds that the differentiation of the duties of doctor, nurse, and midwife constitutes one of the most difficult problems of maternal care even up to the present day. In a recent address Dr. John S. Fairbairn mentioned among four conclusions the following: "that better teamwork between medical practitioners and midwives, and between both and the public health authorities, will add greatly to the efficiency of the maternity service."

Before discussing present-day maternal care in England and Denmark, it may be of interest to consider briefly the status of maternal care in some other European countries. One or two general statements may be made regarding conditions in countries of Central Europe. It is true that a longer preparation for the midwife prevails there than in England, and the mechanics of obstetrics, the details of aseptic technic in childbirth, are perhaps taught with even greater thoroughness, accuracy, and attention to detail. As a rule the European schools give an excellent two-year course in midwifery. Three hours a day are devoted to lectures. Baby clinics twice or three times during the week may comprise part of the program, and at intervals of four or five days the pupils are in the labor room for twelve hours at a time. What is entirely lacking in certain of these schools is an understanding that the pregnant woman and the woman in labor are individuals, with social needs and human attributes which require at least as wise and gentle care as does the physical side of pregnancy and confinement.

In most of the European countries, laws controlling the training and practice of midwives have been in existence for many years, while in England it is only about twenty years since the Midwives Act was passed. But in Europe nurses have had no qualifying effect upon the practice of midwifery because there nursing as a profession is in its infancy. Ethical standards for midwives are shockingly low in some of the countries. In one country where a great degree of skill has been attained by the midwife one hears it stated that these women are actually a menace to community health, and that criminal abortion rather than attendance at normal

childbirth sometimes has become their function. Since this is a more lucrative practice, the temptation, to an unprincipled woman, is probably very great.

In a small mountain town, I visited a midwife whose mother and grandmother had practiced midwifery in this same township. She had a daughter who was a midwife, and she herself held the distinguished position of president of the midwives' organization in her province. She had been trained in a French school of midwifery—carefully trained, thoroughly taught over a period of two years—but this training had been so far away in her youth that one questioned whether she would be willing to call a doctor for abnormal cases or whether she would have the ability to care intelligently for such cases herself. The medical supervision legally necessary is more or less a farce in this region. The midwife is not obliged to take a postgraduate course, and though she is necessary to the community, and her position is dignified, her service is not safeguarded as it ought to be.

In another section of the country I visited a school for midwives where the chief midwife, herself a graduate of a two-year course, but many years before, had a real enthusiasm for teaching the mechanics of obstetrics. One could not say that her knowledge of maternal care went further than this. In the ward where the patients were sleeping was an extra bed, and here the midwife on night duty slept in the intervals of giving the patients such care as they received at night. The chief did not think of wearing a uniform; she wore a particolored frock of woolen material which was not washable. Nursing was not known or thought of. The pupils were peasant girls, moral, one believed, and probably

useful in the lives they lived afterward, for they usually married and returned to their native villages where they practiced midwifery.

Administration of Midwifery in England

In England the maternal mortality rate is 3 and a fraction per 1,000 births. In the United States and in Canada it is 6 and a fraction per 1,000 births. In the United States midwives are not generally recognized, and although a conservative estimate of the women practicing midwifery here is fifty thousand, they are not, except in a few states, subjected to centralized training, control, or any sort of standardized procedure. In Canada it is maintained that *such women do not exist.* The fact that the rate of maternal mortality is practically the same in the two countries would seem to show that the unsupervised midwife in the United States is not wholly responsible for our maternal death rate.

The recognition of public responsibility for the care of mothers in childbirth has been long in coming to the Western continent. The medical profession both in Canada and in the United States has been loath to introduce the Old World midwife as a necessary part of the system of preventive or curative medicine in the New World; and the nurses of America have been reluctant to share their work with partly trained women who would be responsible not only for delivery but also for the nursing care of confinement cases.

We usually determine our public health program by considering its bearing upon the general welfare of the community. This we decide by studying mortality rates and resulting economic loss to the community and the

country at large. Our rate of maternal mortality is high and the consequent economic loss great; and it seems evident to me, after a winter's study of the methods of England and of certain other nations, that we in the United States and Canada are far behind in our arrangements for the care of mothers in childbirth, simply because we refuse to consider maternal care an essential, indeed a foremost, concern of the public health authorities.

Even the development of prenatal care in our country has come about largely as a part of the child-saving program and has never had an entirely satisfactory outcome, since it has usually stopped short of care at confinement. We have not, therefore, been in a position to study case by case the end results after, perhaps, months of prenatal care.

In England and Wales maternal care has become a primary concern of the public health authorities and has been thereby to a great extent taken out of the field of curative medicine. Midwives attend, on the average, between 55 and 60 per cent of all births; in some parts of the country they officiate at as many as 90 per cent of all births. They are subjected to central government control and are obliged to call in a doctor for abnormal cases.

Training, inspection, and control of the midwives is in the hands of the Central Midwives Board which was created in 1902 by the Midwives Act. This board, in accordance with the provisions of the Act, consists of fourteen persons, namely: the chairman, appointed by the Royal College of Physicians; one registered medical practitioner appointed by the Royal College of Surgeons, one appointed by the Society of Apothecaries, one by

the Incorporated Midwives Institute (which appoints also two midwife representatives), one by the Association of County Councils, one by the Association of Municipal Corporations; four persons to be appointed by the Ministry of Health, of whom one shall be a doctor, two shall be midwives, and the fourth also a woman; one person to be appointed by the Society of Medical Officers of Health; and one person to be appointed for a term of three years by the Queen Victoria's Jubilee Institute for Nurses (see p. 119). Sir Francis Champney, the well-known obstetrician, has been chairman of the board since its creation twenty-six years ago, and has been present at all except one of its meetings.

The duties of the board are, among others, to regulate the course of training for midwives, the conduct of examinations, the issue of certificates, and the conditions of admission to the roll of midwives; to supervise and restrict within due limits the practice of midwives; to publish annually a roll of duly certified midwives; to frame rules for the guidance of midwives in practice and to punish infringement of these rules.

The Midwives Act forbids any woman who does not hold a certificate of the Central Midwives Board to call herself a midwife or to act as a midwife for gain. The local administration of the Act is, however, entirely dependent on the energy and efficiency of the county councils and county boroughs, and consequently varies greatly. According to a member of the Central Board the spirit of the Act is as yet scarcely operative in some of the rural counties.

Apart from the Central Midwives Board, the Midwives Institute, referred to in the Act, is the most important body of people concerned with midwifery in

England. Established in 1890, the institute organized with the help of its friends a guarantee fund of £1,000 to promote a midwives bill. A Midwives Bill Committee then organized was instrumental in obtaining the following vital points in the bill: (1) The protection of the title of midwife, without which legislation would have been useless, (2) a representative of the Midwives Institute on the Central Midwives Board.

The institute has been, and still is, a great force behind every phase of work for the English mothers. The objects for which it exists are five:

1. To raise the efficiency and improve the status of midwives.
2. To establish a center of information for the public.
3. To provide a good medical lending library for midwives and a clubroom for friendly meetings.
4. To arrange courses of medical lectures and to afford opportunities for discussion on subjects connected with the profession.
5. To do all things necessary to promote the efficiency, comfort, and development of midwives.

General Public Health Organization in England

To help to a clearer understanding of the administration of midwifery in England a brief description is given here of the complicated organization for public health work which tradition has established in that country.[2]

The local health authorities are the councils of the various administrative areas into which the country is divided. These areas are many in number and of sev-

[2] *Notes on Public Health Organization in England,* by Charles Porter, M.D., B.Sc., M.R.C.P. (1923).

eral varieties. The counties are the largest and are historically interesting, as they represent the sections into which the land was primarily divided, probably for governmental purposes. In addition to the counties there are county boroughs, boroughs, urban districts, and rural districts. The county boroughs are large towns having more than 50,000 inhabitants; the boroughs are, or may be, rather smaller and somewhat less important towns; urban districts are also towns and may be large, populous, and important, though for reasons into which it is not necessary to enter they have not been granted by Parliament the title of county borough. The rural districts are, in general, county districts with rather small and scattered populations, but often they consist of several villages. Each type of administrative area has a council differing in some degree from that of the others.

In the Public Health Act of 1875 are laid down the duties of the local councils with regard to the public health, the powers which they are expected to exercise, and the activities upon which they are empowered by Parliament to spend money. One of the most important duties of a council is the appointment of the medical officer of health and the (nonmedical) sanitary inspectors of the area. The officer of health has always been responsible to the council; in himself, apart from this council, he has no power.

In a county borough the town council is the one health authority for all purposes, but outside the county boroughs certain duties (including most environmental hygiene) are undertaken by the town, urban, or rural district council; while other duties (including school and tuberculosis services) are carried out in the same area by the county council.

In the early days practically all health work had to be paid for out of moneys raised locally, with the exception that, provided the medical officer of health and the inspectors had been appointed under sanction of the central authority, half the amount of their salaries was repaid out of government funds. A certain control over local work is at present exercised by the Ministry of Health—as in the past such control was exercised by the central governmental authority which preceded the Ministry of Health—through its power to give or withhold substantial money grants. The local health authorities may be taken to represent the people's will, consisting as they do of individuals selected from all grades of society by the persons who contribute the moneys to be expended on health work.

A National Health Insurance Act, passed in 1913, is contributory and compulsory. Workmen and their employers together pay seven-ninths of the whole, and the remaining two-ninths is paid from moneys provided by Parliament. The employer pays a sum equal to that contributed by the employed in the case of a man, and a little more than that in the case of a woman.

In 1916 a law was passed by which the local government board agreed to pay grants during each fiscal year for maternity and child-welfare work carried out under a number of listed services. The grant paid in each year is determined on the basis of the expenditure incurred through services in the preceding year, and is at the rate of one-half of that expenditure where the services have been provided and are carried on with the board's approval. Grants are also paid on this basis to voluntary agencies.

Provision for Maternal Care

Maternity Benefit. Important to our study is the maternity benefit allowed under the Health Insurance Act. This amounts to a sum of 40 shillings per insured workman. If the wife of the insured is also employed, she may receive another 40 shillings. In this case as much as £4, or $20, may come into the family at the time of the confinement. These unsupervised cash payments are made either directly through an approved society or, if the beneficiary is not a member of an approved society, through an insurance committee established for that purpose. There is a tendency on the part of approved societies to add more benefits in the way of nursing, midwifery, and so on, to those already to be obtained through the Health Insurance Act. It is stated that there is a present surplus in the hands of the approved societies of £30,000,000. Surveys are being undertaken in certain parts of the country to ascertain how many nurses would be needed if nursing were added to the benefits under the Act. From the point of view of developing a sufficiently large group of supervised workers to make the Midwives Act effective in all parts of the country, this tendency on the part of the approved societies opens out an interesting prospect.

Queen Victoria's Jubilee Institute for Nurses. District Nursing in England is administered through a national organization having headquarters in London, and known as Queen Victoria's Jubilee Institute for Nurses. Endowed by the Queen and others, there is an annual income of about £5,000; the difference between that and the annual expenditure of about £16,000 is made up

from patients' fees, voluntary subscriptions, and the like. The work of the Queen's Institute falls into three divisions: training, inspection, and organization of district nurses. Fully trained hospital nurses are taught to be district nurses, and many of these are also taught midwifery. The district training covers a period of six months and is given in one of the eighty-three affiliated "homes" of the institute. On satisfactory completion of training the nurse is enrolled as a Queen's nurse and goes to work under a nursing association affiliated with the Queen's Institute.

Systematic inspection of district nurses is an essential factor of the work of the Queen's Institute; it is carried out by appointees from among the Queen's nurses. Reports of inspections are submitted to the committee of the institute and the result communicated to the nursing associations, which raise money for local activities and function like a visiting nurse association in the United States. In addition to securing a high standard of training and work, the institute acts as an advisory and executive center for the nursing associations with regard to the general organization of the work, negotiations with government departments, and nation-wide programs, such as arrangements with approved societies for payments for the nursing of their members.[3]

From the foregoing it will be seen that the Midwives Act of 1902 found already organized a vehicle for its efficient enforcement throughout the country. Not infrequently one hears regret expressed that the Queen's Institute has never been made the official instrument of the Act. Such a procedure would seem to have certain

[3] Taken from the Thirty-second Annual Report of the Council of Queen Victoria's Jubilee Institute of Nurses (1923).

advantages, although one can see that a voluntary organization such as this is in some respects better as an auxiliary to the local supervising health authority. However that may be, the results obtained by the Queen's nurses and village nurse-midwives [4] leave very little to be desired.

The following report of the institute for the year 1923 is given in full inasmuch as it covers widely separated areas and all varieties of urban and rural living conditions in England and Wales:

QUEEN VICTORIA'S JUBILEE INSTITUTE FOR NURSES

REPORT OF THE WORK OF CERTIFIED MIDWIVES UNDER THE SUPERVISION OF THE Q. V. J. I. FOR THE YEAR 1923

45 inspectors and superintendents in England and Wales have furnished reports from:

373 Queen's nurse-midwives (an increase of 155 on 1920, the date of the previous report)

2,164 village nurse-midwives (an increase of 224 on 1920)

78,072 cases were attended as midwife or maternity nurse (an increase of 4,251 on 1920)

Attended as Midwives

54,554 cases (an increase of 5,474)

Maternal Deaths

81, including deaths from all causes: 14 per cent or 1.4 per thousand births (1920: 1.8 per thousand)

Causes of Maternal Deaths

15 hemorrhage
10 sepsis
10 embolism

[4] *Op. cit.*, p. 28.

10 placental difficulties
4 complications
24 complicated with other diseases
(full details given in uncondensed report)
8 eclampsia.

Infant Deaths

750: 1.37 per cent (1920: 1.10 per cent)

Stillbirths

1,678: 3.3 per cent (1920: 2.6 per cent)
(Ophthalmia Neonatorum, 3 per 1,000)

Medical aid was sought in 18 per cent of the cases (1920: 16 per cent); this is very high but is doubtless owing to the payment of the doctor's fee out of the rates. Forceps were applied in 22 per cent of the cases in which the midwife sent for medical aid.

It will be seen from this report that among 54,554 cases attended by the certified midwives of the Queen's Institute in 1923 there were but 81 deaths from all causes, or 1.4 per 1,000 births. When we remember that these midwives were widely scattered over England and Wales, in remote rural districts, in industrial and mining centers, this figure becomes significant and seems to show that an extension of this service to all localities would greatly reduce the maternal death rate for the whole country.

Village Nurse-Midwives. In many country districts there is neither the type of work nor the money to justify the engagement of a Queen's nurse, yet there is great need of care for ordinary ailments and chronic cases and, above all, there is a great demand for midwives and maternity nurses. A special class of nurses who have not had full hospital training, but have had

training in district nursing and midwifery, is provided for these areas. They are called village nurse-midwives. County nursing associations in affiliation with the Queen's Institute train and supervise these nurses and organize and affiliate local nursing associations. Miss A. M. Peterkin, general superintendent of the Queen's Institute, writes [5] as follows of the village nurse-midwife, and the comparative cost of her service and that of a fully trained Queen's nurse:

As to whether a village nurse-midwife is the best woman for the work she is doing is, at the present time, a matter of opinion, but that is so chiefly because of the medical and surgical cases which may fall to her and not on account of the midwifery part of her duties. (She cannot undertake medical or surgical cases, while a fully trained Queen's nurse can.) Personally, I think that the better-trained, better-educated, and better-class a nurse or midwife is, the better work she does whatever may be its locale, though I agree that the work done by our village nurse-midwives is wonderful.

When a district is sparsely populated and the area is already large, it would not be possible to obtain more work for a fully-trained nurse and, in that case, employing her would cost a good deal more than employing a village nurse-midwife. It is only when the population and area are such as to admit of a fully-trained nurse obtaining more work than a village nurse-midwife can overtake, that the cost works out about the same, taking into consideration the amount of work done. The difference between the cost of a fully-trained nurse and a village nurse-midwife is approximately £40 to £50.

Expenditures for Maternal Care. The following financial statement of expenditures for maternal care in England and Wales in the year 1922-23 was provided by Dame Janet Campbell of the Ministry of Health:

[5] In a letter to the author.

EXPENDITURES FOR MATERNAL CARE
Year 1922-23

	Local Authorities' Expenditures	
	Net	Gross
Midwifery	£ 47,252	£ 59,860
Maternity homes and hospitals	200,788	250,515
Infants' hospitals		

The grant paid by the Ministry of Health to Local Authorities amounts to half the net expenditure, i.e., (*A*) £124,020.

Grants paid to voluntary agencies in the year 1923-24 in respect of expenditures for year 1922-23:

Midwifery, total		£ 31,017
To county nursing associations	£18,339	
To county councils for distribution to unaffiliated district nursing associations	1,164	
To direct grants to unaffiliated district nursing associations and other institutions undertaking district midwifery in large urban areas	11,514	
Maternity homes and hospitals		70,226
Total (*B*)		£101,243

Payments Through	Maternity Benefit		Total
	Men	Women	
Approved Societies	£1,121,000	£175,000 146,000	£1,442,000
Navy and Army Insurance Fund	43,000	.....	43,000
Deposit Contributors Fund	13,000	2,000	15,000
Total (*C*)	£1,177,000	£323,000	£1,500,000

Total (*A*)	£ 124,020
Total (*B*)	101,243
Total (*C*)	1,500,000
Total: Government Expenditure for the Year 1922–23	£1,725,263

This statement shows that the sum of £1,725,263 for the purposes of maternal care passed through the hands of the Ministry of Health in the year 1922-23. One cannot quite say this amount was expended by the Ministry of Health, since the unsupervised cash payments under maternity benefits were of course partly made up of money which came from the workmen. Since the taxes of the people provide the money from which local grants are made, this is also true of the local grants matched by an equal sum from the Ministry of Health.

One is impressed by the wisdom of the so-called "fifty-fifty" plan adopted by the Ministry of Health under Sir Arthur Newsholme in 1916. By this plan a health agency, whether public or private in character, may receive a grant from the Ministry of Health equal to the budget presented, provided the budget of the plans for its expenditure is approved by the Ministry. Many rulings have been made by the Ministry of Health since this Act was passed, and all these rulings are permissive and suggestive in character. For example, a medical officer of health may subsidize the salary of a midwife, may pay the full salary of a midwife, may open a maternity home, or may pay for the upkeep of certain wards for maternal care in a county hospital. If these things are done by the local authorities with the approval of the Ministry of Health, the authorities will receive from

the Ministry half the amount of the proposed budgets. The effect of this ruling has been to stimulate desirable health development, and it has tended to standardize the work for mothers and children throughout the country.

There is undoubtedly a tendency to induce mothers to come to large city hospitals for their confinement, or to be cared for by the district services connected with these hospitals, so as to provide material for training midwives and medical students. This seems an undesirable tendency, inasmuch as the mother is given maternal care free of charge or for a smaller sum than she is able to pay towards the cost of the service, and thus the private practice of midwives and the independent spirit of the community are undermined.

Organization of Maternal Care in London. It seems easier to accomplish good health organization in large centers than elsewhere. One finds in London a consistent application of the system on which maternal care is organized in England. The maternal mortality rates for London are a good deal lower than for the country at large;[6] available hospital beds are adequate for the needs; it is possible for a woman to be brought into a hospital without delay in an ambulance summoned

[6] Distribution throughout England and Wales of mortality of women in childbirth per 1,000 children born alive.

	(All causes)
London	2.98
County boroughs	3.94
Other urban districts	4.03
Rural districts	4.22
All areas	3.91

Taken from Reports on Public Health and Medical Subjects, No. 25, Ministry of Health (Great Britain, 1924), *Maternal Mortality,* Dr. Janet M. Campbell, Table 8, p. 13.

merely by getting in touch with the nearest policeman; there are private practicing midwives, Queen's nurses to give postpartum care, and well-baby centers and prenatal clinics in practically all parts of the city.

One example will be sufficient to show the excellence of the organization: At the East End Mothers Lying-in Home, situated in one of the poorest parts of London, one finds a "lady superintendent" who became a midwife "par excellence" and took a nurse's training for the purpose of filling her present position. In the Thirty-ninth Annual Report of the institution we read that 1,020 mothers were delivered in the Home and 1,262 in the district; one maternal death occurred, and that one as a result of toxemic accidental hemorrhage. The lady superintendent is directly responsible, professionally, to a medical officer who is a private practitioner giving his services. He has associated with him three other private practitioners, who are Panel doctors under the Health Insurance Act and are paid for the time they give to the institution. The lady superintendent has associated with her a first assistant, or so-called "almoner," who admits the patients, conducts the prenatal clinics, and determines whether and how much a patient shall pay for care.

Pupil midwives are prepared by one of the doctors and the lady superintendent for the examination of the Central Midwives Board. The courses of training are specially adapted for those who wish to qualify for appointments under the Ministry of Health. The fees for the courses, which are to be paid in advance to the secretary and which include board, lodging, and lectures, are:

Four months' course (trained nurses only) .. £31
Six months' course[7] £40

The pupil midwives are intelligently taught exactly what conditions must be observed in the pregnant woman and which of these are dangerous and must be referred to the doctor's clinic held weekly. Visits with these midwives to the homes of patients showed admirable care of the mother but very little knowledge of the new baby. One is impressed with the desirability of giving midwives a training in the care of well babies; this is not an easy thing to do, but there is an obvious waste of opportunity unless it is done.

The maternity work from the many large hospitals in London and in connection with the poor law infirmaries is varied but, on the whole, good. A morning was spent with an experienced nurse-midwife, supervisor of the out-patient department work of the London Hospital. It was delightful to find that all the families visited were devoted to the London Hospital and what it stands for. It is difficult to give an impression of the strength of the relationship existing between the old voluntary London Hospital and the people of the neighborhood which it has served for so many years. This relationship is almost a feudal one: the dependents of the hospital have a strong sense of loyalty to the institution and a belief in its superiority over any other voluntary hospital in London.

The principle of separating material relief from health service is not so strong a part of the English system as it is of ours, and while one does not often

[7] Under a new ruling of the Central Midwives Board these courses will be changed to six and twelve months, respectively.

see it abused, the relationship between patient and visitor seems to be somewhat affected by it.

A visit was made one evening with a practicing midwife who is employed by the Charing Cross Hospital. It was an enlightening experience to sit in the patient's one little garret room in a crowded district in the center of London and see what admirable professional care the midwife was able to give her at the birth of her baby. Coming from a country home with very little money to spend for rent and, because of the housing shortage, with almost no choice in rooms if there had been more money, the patient and her husband slept and cooked and lived in this one room.

The midwife brought with her a young woman student of the Charing Cross Medical School, for it is the business of this midwife to teach normal midwifery to the medical students. Simplicity itself characterized the technic, and necessarily so, in these quarters. There were surgical cleanliness, expert knowledge of the mechanics of obstetrics, and a very high type of what might be designated as nursing skill, although in this instance the midwife was not a graduate nurse. The state of mind desirable for the mother was one of her chief concerns, and her quiet, dignified, sympathetic but unsentimental relation to the patient was a thing to be greatly admired. This midwife is in the habit of giving chloral or morphine, and, if she thinks that the patient requires it, she may give that powerful and dangerous drug, pituitrin. To those of us who are brought up under American doctors—and I find also to those who are brought up under Danish doctors—such a practice seems alarming.

Further Needs. Although it seems clear to an observer that the mothers of England are much better cared for in childbirth than are the mothers in the United States, yet Sir George Newman in an introduction to Dame Janet Campbell's *Study of Maternal Mortality* (1924), makes the following statements of the position of England in this matter:

1. Maternal mortality is relatively excessive in England and Wales.
2. Since 1902 maternal mortality has not declined proportionately in the same degree as the death rates from all causes of women at reproductive ages, as the general death rate of all persons at all ages, or as the infant mortality rate for children under one year of age. In fact, the child-bearing mother is not sharing equally with the rest of the population in the improved public health.
3. Maternal deaths are due principally to sepsis (puerperal infection) and to other complications of pregnancy, but deaths due to the former have shown a greater decline since 1902 than those due to the latter cause.
4. The risks to women in their first confinement are certainly greater than in most subsequent confinements.
5. The decline in the birth rate, which obviously may bring about a great general change in the constitution of the people, has exerted a relatively small effect upon the degree of maternal mortality.
6. With respect to the proportion of maternal mortality, England and Wales compare unfavourably with Germany, Norway, Italy, Sweden, and Holland.
7. Excessive rates of maternal mortality are found in the aggregate in the most rural areas and in highly industrial areas (engaged in textile manufactures and coal mining), and especially in certain county boroughs.

There is abundant evidence of maternal deaths that are directly due to the introduction of microorganisms at the time of delivery. A story illustrating the ex-

treme importance of surgical cleanliness of the hands of the attendant is told of an English obstetrician who recently, when taking a holiday in a remote part of the country, found himself appealed to to save the life of a woman dying of postpartum hemorrhage. Before his journey he had made a postmortem examination. There were no gloves and no antiseptic to be found in the rural district, and he explained to the family the danger of operating with contaminated hands. After scrubbing unusually long and thoroughly with soap and water, he stopped the hemorrhage by manual extraction of the placenta; but the woman died of puerperal sepsis within a few days.

Puerperal sepsis still accounts for the greater number of maternal deaths. In England in 1922, out of a total of 2,971 maternal deaths, 1,079 were from this cause. Many such deaths, though not all, are preventable through the consistent use of aseptic surgical technic. There is apparently a definite group of cases of puerperal sepsis, however, which is not susceptible of direct explanation, and the consensus of medical opinion seems to be that research on these cases is greatly needed. Where ideal conditions prevail in maternity hospitals there are fewer deaths from puerperal sepsis in the hospital than in the country at large.

Next to puerperal sepsis as a cause of death in childbearing comes hemorrhage and accidents of pregnancy. Next to these come toxemias, and after that preexisting or intercurrent organic disease. Hemorrhage and accidents of pregnancy as well as toxemias, occur most often in hospitals, while sepsis is most frequent at home. The hopeful element in the situation seems to be that proper prenatal care results in a very considerable saving of

life wherever it is carried on. The most serious difficulty appears to be the magnitude of the task of reaching all the pregnant women in England with this adequate measure. The geographical element makes it, up to the present time, a certainty that all three of the above-mentioned causes will produce preventable deaths in many parts of England and Wales. Dr. Campbell says: "Comparing aggregate urban with aggregate rural districts in the North and Midlands, puerperal fever caused 5 per cent to 11 per cent fewer deaths in the rural than in the urban districts; from other effects of child-bearing the mortality is in every case higher in rural than in urban districts, notably so in the Midlands where the mortality is 15 per cent above the figure for urban districts." [8]

The following tabulation of the needs of midwifery in England was made by a member of the Midwives Institute, herself a practicing midwife, an able teacher, and a pioneer who had taken an active part in the improvement of midwifery from the time she entered the service:

1. If England had begun by offering a longer midwives' course with more serious educational implications, it would have been better.
2. Such an education would have made the present "inspection" and control unnecessary. The loss of dignity to the group in having to be inspected tends to keep better women away.
3. Normal deliveries, in charge of midwives, with doctors on call, will eventually, and should, become a part of health center administration. State subsidy and pensions for midwives are a necessary part of this.

[8] *Study of Maternal Mortality.*

4. The present economic status of the midwife is hopelessly low.
5. Research into the causes of maternal deaths is urgently needed.
6. Further education of the medical student in obstetric care is necessary.
7. Public opinion should be roused to recognize the importance of the state of mind in which a mother can best carry through the dangers of childbirth. Both family and patient bring great pressure to bear on the doctor to use forceps, and he all too often disregards everything but the immediate termination of labour. The psychology of labour is too much neglected.

The word "midwifery," in England, is used commonly and in a connection never heard in the United States. For instance, a doctor practices "midwifery" or a medical student "takes his midwifery." Midwife seems to us on this side of the Atlantic almost obsolete. It never was an adequate term, meaning in its most popular days nothing more significant than *with the woman.* It would seem wise to find another English phrase to express what is meant by a well-educated, professional woman who is an attendant at normal childbirth.

In France the *sage femme,* or "wise woman," has real dignity of meaning and in Denmark the *jordemoder,* or "earth-mother," has at least the historic significance attached to the Roman father who pronounced life or death sentence on the baby raised up from earth by the attendant. The term "maternity nurse" signifying a woman who has become a skilled accoucheuse, fittingly describes the person whose work is the subject of this study. It seems an unnecessary handicap to make use of the word "midwife" at all, for persons so termed are to be found with all varieties of social equipment—

from that of one recently stricken from the roll in England because she was too ignorant to learn to read a clinical thermometer, to the Danish *jordemoder* who went to Court balls while she was in training in the State School for Midwives, her sister being a lady-in-waiting at Court at the time.

In theory a high standard is universally set for the midwife. Professor Couvelaire, of the Faculty of Medicine in Paris, Dr. J. S. Fairbairn, of St. Thomas's Hospital Medical School, London, Professor Hauch of Copenhagen University, all agree that an educated woman is best for this work and that she requires knowledge of nursing and of social and public health methods, as well as a very exacting training in the theory and practice of the care of the parturient woman. Florence Nightingale said, "Between midwifery and all other hospital nursing there is this distinction—the operator is herself the nurse, and the head operator or midwife ought to be a woman."

At its best the life of a person, whether man or woman, doctor or midwife, who attends labor cases, is a very exacting one. At its worst, it becomes so difficult that the superior type of woman described above cannot continue in it. The chief obstacle to establishing an order of obstetrical assistants in England lies in the economic and social position they would occupy. The social standing of the midwife in the community may be measured by the fact that no one who can afford a doctor ever thinks of employing her, even though it is theoretically conceded that she is better at normal births than a doctor is. The psychology of having a woman who is trained to wait patiently, to let things take their course without interference, to sustain the mother with

the sense of that unhurried normal outcome goes far to produce the desired result, just as a good nurse does something in the care of a patient with pneumonia that a doctor cannot do. Public opinion on this point has still to be formed in England.

The earning capacity of English midwives is extremely low. The fees may run from £1, 1s. up to £1, 10s. per case. If a midwife should average £1 on each case and have from 150 to 200 cases a year—and that is, perhaps, as many as she can handle properly—she can make only £150 to £200 per year. But it is uncommon to find a midwife who has been able to build up so good a practice. An experienced midwife stated that unless a practice was inherited (she had taken her mother's), a woman could not, in the working years of her life, build one up to a point where a proper living could be made from it alone.

The doctor's relation to the practice of normal delivery is in many instances not good, in that he is much too ready to regard the use of forceps as the regular procedure in delivery, and he is inclined to consider the midwife as a rival. Ideally, a doctor and a midwife ought to be engaged for every mother. The midwife will then call the doctor if she needs him or if the patient wants him.

In a recent report of the Scottish Departmental Committee on puerperal morbidity and mortality (1924) the following statement occurs:

> We are convinced that every pregnant woman should be encouraged at an early date to put herself under the supervision of a medical attendant, so that her capacity to pass normally through pregnancy and labour may be determined; if necessary this supervision should be provided by the public health au-

thority. The examination which is necessary is not within the competence of the midwife alone, and indeed requires special knowledge and training on the part of the medical practitioner.

It is natural that a private practitioner would wish to have an intimate connection with the new babies in his families, and surely it is desirable that a family should learn to look to its doctor when the baby is coming. The experience of Denmark leads one to conclude that the important point is to draw the distinguishing line between what is best done by the midwife and what by the doctor: normal childbirth, in the view of Denmark, is one of the functions of nursing as it is expanded in the specialty of midwifery. In establishing conditions of a state subsidy for maternal care it would be advantageous to take serious thought of the place which it is desirable for the family doctor to hold in relation to normal childbirth. During this study it has again and again seemed evident that a better relation could be established between doctor and midwife if one were starting out afresh with public money to be spent for maternal care. In the United States when visiting nurse associations have been able to afford a so-called maternity nursing service the doctors of the district have always welcomed it. It relieved them of some responsibility and did not interfere with the fee—if there was a fee to be collected.

Training in Maternal Care

In dealing with the question of adequate preparation for the practice of midwifery, the Central Midwives Board is confronted with a threefold problem: the education, training, and experience necessary for (a) medi-

cal students, (b) nurses, and (c) midwives. Even a superficial comparison of the requirements for the training of a nurse or a midwife and the requirements for educating a medical student makes clear the difficulties of the present position. A midwife must, before getting her certificate, have attended not less than twenty births. It is difficult to secure an equal clinical experience for a medical student, and in some good medical schools he does not personally attend more than six or seven births. That the doctors who are expert consultants for these midwives have so slight a training in normal childbirth is an absurdity apparent both to the midwife and to the doctor. Nor does the previous medical education of the student take the place of clinical experience. "Twenty personal deliveries," says Dame Janet Campbell,[9] "are none too many to qualify a practitioner in this branch of medicine, even if the most is made of each case."

In England midwifery is a part of the professional equipment of a nurse and is usually stated as a requirement when a position is advertised. Practically all nurses graduating from good hospital training schools take the course in midwifery and pass the examinations of the Central Midwives Board. This group makes a large number of students, each of whom must be provided with at least twenty "cases." Comparatively few nurses practice as midwives or intend to do so when they take the examination. There are over fifty thousand women on the midwives' roll for England and Wales, about sixteen thousand of whom have given notice of their intention to practice. The testimony of teachers

[9] Ministry of Health Publication, Physical and Medical Subjects, No. 15 (1923).

of midwifery is that the nurse pupils are less desirable than the women who are not nurses but intend to practice afterwards. An English nurse spends at least three years in training, and in certain hospitals she must stay on a fourth year unless she is in a financial position to repay the cost of her board during training, in which case she is free to go. During that time she is not taught health visiting nor any maternity nursing, as American nurses are. Often she takes the midwives' course merely to ensure her good standing as a nurse, and at a time when she is already fagged by three or four years of hospital training; it is therefore not surprising if she is a somewhat perfunctory student. The student midwife is usually, though not always, a woman of a good deal less education and social background than the nurse.

The institutions where midwives are taught are not schools of midwifery such as are found on the Continent. The Central Midwives Board has laid down the requirements for training and has set the examinations to be passed. Anyone capable of conforming to these regulations may train midwives in England provided the approval of the board is secured. Training has been observed in the following kinds of institutions:

1. Maternity homes subsidized by the Ministry of Health.
2. Voluntary hospitals both general and maternity and in the "districts" attached to them as practice fields.
3. Poor Law infirmaries.
4. Private maternity homes (practicing midwives approved as teachers).
5. Queen's Institute maternity homes.
6. Army Maternity Hospital for the wives of soldiers.
7. Combination courses which permit lectures to be taken apart from the institution giving the practical work.

In comparing the school specially arranged for the student with these varied institutions designed primarily for the care of the patient, it seems clear that the school for midwives *per se* is better. Certainly it is not so difficult for the teachers.

As has been indicated, the development of better conditions of education for midwives in England is handicapped by the lack of a central school connected with an educational institution and supported by the state. Denmark has this type of school and there are about four hundred applicants for the forty yearly vacancies. The Central Midwives Board is fully aware of the need for better teaching of midwifery; the committee of the Midwives Institute is preparing a curriculum for a teachers' course which the Ministry of Health has undertaken to subsidize.

The British Hospital for Mothers and Babies at Woolwich approximates a school for midwives, but it has no connection with an educational institution nor has it any specific relation to the Central Midwives Board or to the Midwives Institute. Were it not for this isolation, one would be inclined to approve a considerable extension of its teaching facilities. It is admirably equipped and the training is thorough and good.

Recent rulings of the Central Midwives Board (1925) extended the period of training for midwives, so that a nurse must now spend six months and a woman who is not a nurse must spend twelve months in training. This change in the rulings will tend to raise educational standards and to emphasize the need for some one educational center for the original theoretical and practical training, and for a postgraduate course to which gradu-

ates would return at intervals, in order to keep up to a standard of efficiency. Already at Camberwell, in the southeast district of London, an excellent beginning has been made for such a postgraduate course. The chairman of the committee in charge of this activity is Dr. John S. Fairbairn of St. Thomas's Hospital and Medical School. The practical work is given in connection with York Road Maternity Hospital and in the district immediately surrounding the center. The curriculum is admirably adapted to the needs of the practical midwife.

Though the quarters at 77 Southampton Street are very crowded, it has been thought an advantage to have this center in the midst of the neighborhood where the work is done. There is distinctly a communal atmosphere about the house; the district has been worked up to depend upon the center, and the mothers of the neighborhood turn to the house for help in all sorts of difficulties. It is in no sense the part of an educational institution to develop the activities of a social settlement, and yet the midwives who come in to renew their knowledge undoubtedly gain a great deal from the good social work being done there. The spirit of the place is admirable. The cost of taking the two months' graduate course, however, is 16 guineas, and this is a really serious matter when one considers the low economic status of the practicing midwife. Again one recalls Denmark, where the state pays all expenses for such graduate courses. An interesting practice was observed in East Sussex, where scholarships have been provided by the local supervising authority, so that midwives of the district may be sent every year to London for the postgraduate course.

Maternal Care in Two English Counties

Durham, A Mining County

I gave a week to the study of maternal care in Durham County, not because such work is better organized there than elsewhere but because the area presents some of the greater difficulties to the enforcement of the Midwives Act.

It is a mining community, agriculture providing employment for a comparatively small number of the working people. Like most English communities, its one million people are of the old stock of the county. To visit among these people with the nurses and midwives and compare experiences with those encountered in such visiting at home gives a vivid realization of the greater difficulties of dealing with our foreign-born population. There is, however, one compensating advantage in the newer country, namely, freedom from the fixed traditions which grow up where there have been generations of the same neighbors, the same houses, the same occupations. Our new and varied stock seems far more adaptable.

The housing conditions in Durham are very bad even though a great effort has been made in the past ten years to improve them. On the other hand, the housekeeping in the miserable quarters in which the miners live is remarkably good. Only one dirty house was found in all those visited, and that belonged to a housewife whose mental capacity was obviously small.

Colliery houses generally have three rooms. The old

ash-closet is still present with all its ancient evils, though new sewerage works are under way in several localities. The families are usually large, often consisting of eight or nine children. The worst of the present housing shortage is that even one of the old-type three-room houses has to be shared in many instances with a second family. One was visited which housed six in one family and five in the other. The religion of the mining people in Durham is largely Methodist or Primitive Methodist, and one is told that this tends to shut out the idea of voluntary limitation of the family. However that may be, the birth rate shows no such marked drop as in some other districts, though it is lower than it was twenty years ago. There are about 25,000 births a year, and maternal mortality for the period 1919-22 was 4.25. The sturdy character of the people, both men and women, is noticeable. They are, on the whole, industrious, courageous, and cheerful in the face of exceedingly difficult lives. It is a question whether the miner's life or that of his wife is the harder. For example, one mother was visited who had recently had her eighth child. She is thirty-five years old. She was found, during pregnancy, to be losing weight and investigation showed that she got up at 3 A.M. to provide a meal for the son of 14 whose shift began at that time, again at 5.30 to receive her husband and prepare his bath and a meal for him, and again at 7 to get the children ready for school. Another woman of this district had never been out of the house for the whole duration of eight previous pregnancies, because her husband thought it unseemly that she should do so.

Dr. Eustace Hill, medical officer of health for Dur-

ham County, says in his Annual Report for 1923, in regard to a special inquiry into causes bearing on the incidence of puerperal sepsis and maternal deaths:

> Puerperal sepsis has accounted for about 25 per cent of the maternal deaths under inquiry, eclampsia for 14 per cent, hemorrhage for 14 per cent, valvular heart disease with or without complications for 11 per cent, pneumonia and other chest conditions for 13 per cent, and other conditions for 23 per cent. The greatest mortality was in the age group 30-39 years, and was higher in multipara than in primipara, 68 in the former against 22 in the latter. The general health of the patient does not appear to have materially affected the number of maternal deaths, since nearly as many died of those who were reported to be in good health as among those with a history of ailments and complaints. Contrary to expectations a greater number of deaths occurred where home conditions were reported as good than among those whose houses were distinctly poor and unsatisfactory.

In certain villages visited it is still true that the Midwives Act seems not to have affected conditions at all. This is due to local prejudice, to the fact that the old "gamps," or handy-women, have been a part of the neighborhood for a long time and are strongly intrenched. Occasionally, even, it happens that a local doctor will protect one of these women, finding her less annoying than the woman having a Central Midwives Board certificate. It is within the powers of the county medical officer of health to place a midwife in such a locality, but this is of little use if she is to be frozen out by the people when she is established. As is the case with all new things, it takes time in England to get the qualified midwife accepted.

As fast as it can be done, the several institutions which

contribute to maternal and child welfare are being set up, namely, a prenatal clinic in connection with the baby welfare center, a maternity hospital, and a resthouse where mothers and babies may be taken for a time, especially with the purpose of reestablishing breast feeding. One questions the value of the prenatal clinic which has no link with the confinement, although it must, even under these conditions, have a limited usefulness. The results obtained in the infant welfare campaign in Durham County are amazing: the infant mortality rate fell from 135 per 1,000 births in 1914 to 86 in 1923. This drop has occurred in the last nine months of the first year of life. Dr. Hill states that there is no doubt whatever that a large proportion of deaths in the first three months could be prevented if prenatal conditions were improved. It is a tribute to the superior intelligence of these Durham County mothers that they faithfully attend the baby clinics of the county health authorities. The clinics are kept open for a whole day a week and have an average attendance of one hundred or more.

Durham County is not coordinated in its health activities in the effective way seen in East Sussex and Hertfordshire. There are no less than four women health officials, each directing one part of the program for mothers and babies, namely: a county inspector of midwives, who nevertheless does not inspect the seventy-seven midwives of the Queen Victoria's Jubilee Institute for Nurses and who does not visit homes with any midwife; a superintendent of the Queen Victoria's Jubilee Institute for Nurses who, under the Ministry of Health, inspects those seventy-seven midwives mentioned above; a woman doctor who is chief of the well-baby work but

who has no official control of the seventy health visitors who do the home visiting from the baby clinics and who are under the direction of a superintendent of home visitors.

There is an effort on the part of the Ministry of Health to improve the education of health visitors and also to influence the nursing authorities to include more public health teaching in the nurses' training. A recent Act of the Ministry of Health states that:

On and after April 1, 1928, the Ministry of Health will not approve the appointment of a woman for the first time as health visitor, unless she:

(1) is a trained nurse, as defined in paragraph 1 of the conditions of grant, who has obtained the certificate of the Central Midwives Board and has completed an approved course of training in public health work, lasting for at least six months; *or:*

(2) has already undergone a course of training of two years' duration recognized under the Board of Education (Health Visitors' Training) Regulations, 1919, together with six months' training in hospital, and has obtained the certificate of the Central Midwives Board.

This will tend to unify the services described above.

There are in the county thirty village nurse-midwives such as are described on p. 122, but the tendency of the Queen's Institute in this county is to add to the number of Queen's nurses, rather than to the village nurse-midwives, because the former are able to perform a greater variety of services and are better educated women than the latter.

In a small rural area one of the Queen's nurses, who also practices midwifery, was visited and a morning was spent with her in the homes of patients. She is

a graduate nurse, had taken the prescribed training in midwifery, graduated from the Queen's nurses' course and was, at this time, doing her first independent work. The responsibility was weighing hard upon her but she was meeting it well. Her personality was very pleasing. She had not yet been a year in the township which included four small hamlets. She had followed a village nurse-midwife who was not satisfactory, and it was interesting to see how her maternity cases were increasing. It is clear that the gravest responsibility rests upon this comparatively inexperienced girl, but her thorough technical education fits her to meet the responsibility better than a village nurse-midwife could do. She must recognize those symptoms of disease and discover those indications of difficult labor which may be found during pregnancy. This is truly a hard task both in itself and because the mothers think it foolish to come for examination. The nurse was questioned minutely about her prenatal work. She believes that the discovery of an abnormality or a foreseen difficulty would furnish her with an argument with which to persuade the mother to take the necessary precautions. Her list of patients was growing, through the patients' appreciation—not, as yet, through that of the doctors, who were not all of them glad to have her as a possible rival in the field of midwifery. One constantly felt, in this connection, that if it were possible to engage both a doctor and a midwife in each case it would make a more harmonious atmosphere.

The labor vote at present is holding out against the further development of "voluntary" baby welfare centers because there seems to the workmen to be too much

"patronage" by the leisured class in this method, although to the officers of health this does not seem to be the case.

To sum up: Durham County has a high maternal mortality rate. Conditions are difficult because it is a mining region and conservative in spite of its labor principles. It does not readily coordinate its activities. There are 202 midwives who have notified the authorities of an intention to practice: 139 were trained and 43 were certified under the old order before the Act was in force. Nineteen are operating under the county midwife scheme, *i.e.*, are paid by the county assisted by subsidy from the Ministry of Health. Of 1,296 cases attended, the midwives acted alone in 1,141 and as doctor's assistant in 155.[10] There are still areas without a midwife, and still "gamps," or handy-women. In addition to the National Health Insurance which provides only for a worker, not for his family, except in the case of unsupervised maternity benefits, there are in the county so-called "medical clubs." If a miner pays a shilling every second week to one of these clubs his family is entitled to full care from one of the private practitioners who make up the club. The clubs tend to prevent a woman from calling in a midwife since she is entitled to a doctor's service.

It would seem that two things are necessary to the further extension of the practice of the Midwives Act in England, namely, a better relation between midwife and doctor and better salaries and living conditions for the nurse practicing midwifery as part of a general service, as well as for the midwife *per se*.

[10] Annual Report of the Medical Officer of Health for Durham County (Dr. Eustace Hill), 1923.

Lancashire, An Industrial County

In the county of Lancashire studies of maternal care were made in two large cities, Liverpool and Manchester, and in one small town of 13,000 inhabitants; short visits were made to the Queen's Training House in Rochdale and to the one in Salford. The county of Lancashire is one of seven counties having a large number of parishes unprovided with midwives. The maternal mortality rate of the two great industrial cities, however, is wonderfully low: in 1922 it was 3.6 per 1,000 births in Liverpool and 3.2 in Manchester. In that year Liverpool had a percentage of 73.2 births notified by midwives and Manchester a percentage of 60.4. One finds, of course, good maternity hospitals in both cities. There is an organization of "Home Helps" in Liverpool, and a resthouse where waiting mothers are taken if home conditions demand it.

Rochdale is one of the county boroughs having a high maternal mortality rate; in 1912-22 this was 7.05 per 1,000 births. This is the third worst rate of all the county boroughs. It is therefore interesting to note that no attempt has been made to connect the midwifery work of Rochdale with the admirable work being done by the Queen's nurses from that center.

Salford, on the other hand, is thirty-ninth from the bottom of the list with a maternal death rate of 4.46. In this smoky, damp, factory city, which is geographically a part of Manchester, the Queen's Institute center does conduct midwifery.

In a small town we saw an interesting illustration of

two of the Queen's nurses working out together the midwifery and general nursing services. One does the former type of work and the other the latter, but it was evident that neither of them knew much about the care of a young baby; there was no teaching in regard to feeding, which was obviously needed, and none about making a crib, about protection from cold, or about the clothing.

These two nurses live in a cottage provided by the local organization of the Queen's Institute and use bicycles to get about. Unfortunately, their lives are lonely and isolated and their holidays are too short to enable them to visit their friends or reach a place where they can find diversion. About 110 confinements a year fall to the lot of the nurse. The doctors do not really want her, considering her a rival, and there is a popular midwife of the old type who still has a good many of the cases. The medical officer of health, however, is very much the ally of the nurses.

Prejudice makes it hard to introduce a new worker, *i.e.*, a trained midwife, into a remote country town or village. But when she once gains a footing she makes her way rapidly, because her care, which includes good nursing, is demonstrably better than that of the handywoman. In the large cities, even where housing and industrial and social conditions are bad, the organized facilities for maternal care insure better results.

Midwifery in Scotland

The Midwives Act for Scotland has been in effect only a few years. A recent visit to Edinburgh and Glasgow showed that the ideal towards which Scotland

is working is identical with that of England. A recent report of the Scottish Departmental Committee on Puerperal Morbidity and Mortality clearly sets forth the situation. As it comes from a distinguished group of Scottish obstetricians and public health authorities, I quote from it at some length:

Preventible Mortality

17. The view has been put before us that maternal death is in some degree a tax which the woman as an individual, and the community in general, must bear as a condition of fitness for survival. This may be so, but the evidence we have received is unanimous on the essential point that the present maternal mortality of Scotland is reducible. . . . Intercurrent diseases may have their special dangers provided for; the toxemias and especially eclampsia can usually be foreseen and avoided; hemorrhages may have their dangers diminished by early supervision; shock and exhaustion may be avoided by the early discovery of pelvic disproportion or the correction of malpositions; and the idea of preventibility is so interwoven with the history of sepsis that the whisper of the word evokes at once the suggestion of failure.

Morbidity: Other Morbid or Abnormal Conditions

24. It is certain that puerperal mortality is but a section of a much wider group of cases of puerperal morbidity, but we have no evidence that enables us to make any estimate of the extent of such morbidity apart from sepsis. The gynecological statistics of certain hospitals for a period of years have, however, been furnished to us, and returns have also been made by antenatal clinics.

Late Morbidity

26. The morbidity due to puerperality is not merely synchronous with it but often much later. Of 10,000 gynecological hospital cases, 65 per cent had borne children and 28 per cent

suffered from disabilities attributed to previous confinements. . . .

Environmental Factors

27. We have made enquiry into the relation of environment to puerperal morbidity and mortality and have obtained a large amount of evidence bearing on this aspect of the question.

28. . . . Our evidence does not show that the effect of bad housing, overcrowding, and uncleanliness is of much weight statistically, at least in cases of normal delivery.

Health in Pregnancy

36. The association of puerperal mortality with ill-health during pregnancy appears to be even greater than would be anticipated. In investigating an unselected series of deaths one witness found two-thirds of the pregnancies associated with definite ill-health. In a similar investigation another witness found the death rate following unhealthy pregnancies five times as high as for healthy pregnancies.

These facts again throw into relief the paramount importance of antenatal care.

The Work of the Medical Practitioner and of the Midwife

40. We have been deeply impressed by the accumulation of evidence showing that within its own range and under suitable conditions each type of professional attendance, by midwife or doctor, produces satisfactory results; and we are convinced that in the interest of the community as a whole the difference between the work for which the doctor should be responsible and that for which the trained nurse or midwife may be responsible should be frankly recognized, and the work of all so coordinated as to secure cooperation in their respective activities.

. . . The abnormal case is suitably dealt with by the doctor at home, or is sent to a hospital. The normal case is attended by the midwife, who knows that the doctor's services are immediately available if any difficulty or emergency arises.

Midwifery in Denmark

In 1714, or nearly two hundred years before England followed her example, Denmark established a Midwife Commission and also provided by law for a state examination of midwives. Substantially the same law is in force today. One is shown a record book which the commission purchased in 1739, having in it an entry of $4.00 which had been exacted from a certain midwife as a fine, one regrets to add, for drunkenness. In this book the commission was to make "important entries," and it is still in active use for this identical purpose.

"Rational instruction" for midwives was established in 1787 and has ever since been conducted by doctors assisted by midwives and nurses, so that Denmark has been actively engaged in regulating the education of midwives for 115 years longer than England. There is only one school of midwifery in the country—the "Reighospitalet," or State Institution, which is connected with the University. There are but two lying-in hospitals in all Denmark, the larger one being in Copenhagen. It is divided into two departments and forms part of the State Hospital. One department is utilized for training medical students, the other is the National Midwifery School.

To understand what the hundred years of experience has done for this school it must be visited and compared with other schools for midwives. It seems, when contrasted with others, as nearly ideal as an educational institution for midwives can be. The building, owned by the state, with its classrooms, living rooms, and equipment for teaching, is most convenient and attrac-

tive. The forty students, admitted in the fall, live here and lead a very strenuous life during the twelve months of the course. Presently it is hoped to make the course cover two years and include no more than it does now, thus allowing the students a longer time in which to assimilate the same material.

Denmark has about 1,100 midwives at present, somewhat too large a number, it is thought. Of these, 735 are district midwives. The longer course will effect a reduction in numbers, thirty candidates being admitted and thirty graduating yearly. The profession is so popular that it would probably be easy to recruit all the students from the best educated families of Denmark, but this is never done; on the contrary, great care is taken to maintain a democratic selection of candidates. There is an average of 400 applicants yearly for the forty places in the school. Applicants for admission to the course are nominated by the district doctors (medical officers of health). Those accepted by the director of the school and the chief midwife are given a month's trial. Any found unsuitable are sent home at the end of that time. Candidates must have the equivalent of, and somewhat more than, our high school education and must be between twenty and thirty years of age. The course of study is intensive. Professor Hauch, the full-time director of the school, his two assistants, and the chief midwife give lectures and quizzes. There is excellent individual teaching. I attended two classes, and although Professor Hauch's quiz was given in a language of which I understood not a word the beauty of his method of teaching was quite apparent. The midyear quiz was in progress, and each student was being given the final grading for the first half of the

course. Each of the forty was then privately interviewed by Professor Hauch and told her weak points as a student. Two, at the time of the visit, were told they must withdraw or take a second year in the school. The practical teaching was no less good. A lesson in delivering, where the presentation was difficult, was observed. It was somewhat of a shock to discover that the dummy contained an actual museum specimen, but for a student to deliver this real dead infant instead of the usual leather doll made the relative value of the two methods quite apparent. Each student delivers by herself at least forty cases before she graduates. She sees many more than this, for she is present by day or night when anything abnormal occurs or any difficult piece of technic is undertaken. The chief midwife is a remarkable person, and both she and Professor Hauch are enthusiastic teachers. Final examinations are conducted by Professor Hauch, a member of the Board of Health, and a midwife appointed by the Board of Health. On graduation the midwife is given a first, second, or third class diploma. Those receiving first or second grade ratings are awarded prizes. Postgraduate courses lasting five weeks are given at the school twice a year. While they are not compulsory, every midwife avails herself of them at least once in her career. The state pays all the expenses of these courses, even to the carfare of the midwives.

A midwife in the small town of Lejre, near Roskilde, was visited. Under a national legislative act the town authorities are obliged to build or provide a house for the midwife, put in her telephone, furnish her bag and equipment, and provide also taxi service when necessary. She is paid a minimum salary of 700 kronen

which is supplemented by fees receivable from the patients themselves, according to a graded income scale fixed by law. If the income thus obtained is too low, it is supplemented by the state. The midwife's salary is subject to increase up to 1,000 kronen, and she is pensioned at the age of sixty if she chooses to retire then. At sixty-five retirement is compulsory.

The midwife's position is as much respected as that of any valued family doctor. Every mother in Denmark has a midwife no matter what her class or income. The obstetricians always employ one, even though they may expect to be present throughout the delivery. The district midwives are directly under the district officer of health, and bear exactly the same relation to the National Board of Health as do the doctors. There is a delightful relation between the district midwife and the district doctor. Since his district is large he may have as many as twenty-four or twenty-five midwives under his technical charge. He meets them once a year at the largest center in the district. He gives a lecture on that occasion, there is discussion, he inspects the midwives' equipment and record book, they have a social afternoon coffee, and that constitutes all the inspection required.

All the most difficult problems connected with a service of midwives as part of the public health program of a country seem to have been met and wonderfully adapted to the local needs by this remarkable nation. These problems include: relation to practicing doctors, selection of good personnel for the Midwives' School, development of a first-rate educational institution, distribution to the localities most in need of midwives until the whole country is covered and yet not overstocked,

control of supply in relation to demand, proper economic and social position of the midwife, postgraduate courses to keep her professionally up to date.

There are about 3,500,000 people in the country and somewhat under 75,000 births annually, with a gradually diminishing birth rate. The maternal death rate from puerperal sepsis is 1.0 per 1,000 births, the general maternal death rate is 1.75 per 1,000 births. Hospitals are luxurious and the use of them universal. Since the state provides them, they seem in a unique way to belong to all the people. The atmosphere, medical and nursing care, buildings, and equipment are like those of the best private hospitals elsewhere. The cost to the state is met in several ways, the Sick Benefit Club System being one of these. There is a health insurance system in Denmark, which, though not compulsory, is in general use. The social legislation of the country is so advanced that it seems, in certain connections, to have made elaborate public health organization unnecessary.

Maternal Care in the Future

There are more than 50,000 midwives in the United States, not a large proportion to our population of 120,000,000 if we were convinced of the need for midwives; but we have not been convinced of this. Moreover, except in a very few states, their practice remains uncontrolled; and ours is the only country where this is true.

Whether one would attempt the complete abrogation of these women, or would educate and police them, with the idea that they are still an indispensable instrument in the handling of the problem of childbirth in civilized

nations, was the question raised by Dr. William R. Nicholson in a lecture delivered in Philadelphia four years ago.[11] Dr. Nicholson says:

> The former plan, namely, their abrogation, has been abundantly proved impossible by the experience of the civilized world, at least for the present; but . . . I shall consider briefly why it is concluded that the midwife . . . in this progessive and enlightened Twentieth Century [is] . . . essential to the delivery of the poor.
>
> It seems almost incredible that anyone, not a confirmed idealist, cognizant of conditions as they exist, will fail to realize . . . that the most vital and compelling reason for considering the midwife as a necessity today is that without her aid it would be impossible to care for the cases of childbirth in any large city or other locality in which a large portion of the population is composed of poor people. It is perfectly true that some . . . hold this statement to be rank heresy. It is also true that certain communities believe that they do not need the midwife, and that if she were done away with their charitable institutions and physicians and nurses would be able to care for all of these women: but I can confidently assert that those holding such views are self-deceived.
>
> . . . Do you realize what delivery in unskilled hands means? If the case be a normal one in essentials, and if it be not interfered with by ignorant attendants, the result may be perfectly satisfactory; but ill-advised interference easily converts the normal into the abnormal, while among the many cases pathological from the start . . . there are . . . appalling tragedies occurring daily. . . . Do you realize that here in America, in this Twentieth Century, many thousands of women are delivered each year in identically the same careless and ignorant fashion as in medieval times, save that the terrible mutilating operations upon the child are not nearly so frequent? Finally,

[11] "An Anachronism of the 20th Century—The Midwife," by William R. Nicholson, M.D., 1921. Lecture III of the Nathan Lewis Hatfield Lectures, delivered before the College of Physicians of Philadelphia, February 18, 1921, and reprinted from The Transactions, pp. 9, 10, 30.

do you know that a large proportion of the foreign element would have received better and more skillful treatment in their own lands than we give them?

The present study was begun with an open mind, I believe, though perhaps with a tendency to hold that the introduction of another type of professional worker in the United States would be a retrogressive step. My observations in England have thoroughly convinced me that Dr. Nicholson is right in the foregoing statement. The Midwives Act of England was passed because of the conviction that a large number of women were economically unable to have proper care at the time of confinement. All the evidence seems to the writer to be of a nature to endorse the wisdom which made the Midwives Bill a law in 1902; but while this is true, it is also true, and very disappointing, to find that statistical evidence gives little indication that maternal mortality is decreasing in England. Fairbairn says:[12]

The proportion of maternal deaths per 1,000 live births was 4.6 in 1860 and 5.7 in 1892: taking, however, the five-year intervals, which give a more accurate idea than single years, the quinquennium from 1891 to 1896 showed a maternal death rate of 5.49, after which there was a marked fall up to 1906-1910, when the rate was 3.74; after this a rise to 3.88 occurred in 1916-1920. The rates available for the last five years are:

1918	3.55
1919	4.12
1920	4.12
1921	3.91
1922	3.8

Still more disappointing is the absence of any decided diminution in the septic rate. . . . The reason for the failure to diminish the childbed sepsis rate is still to find.

[12] *Gynæcology with Obstetrics,* Chapter 34.

We must then face the fact that little change for the better has come about in the twenty years since the Midwives Act was passed. In this connection the statement found in Part I of the recent Scottish report on puerperal morbidity and mortality may be quoted: [13]

Sources of Fallacy in Statistics

4.[14] Before useful comment can be made on the figures of this report it is necessary to consider their reliability as a source of facts relating to maternal mortality. There are three possible sources of fallacy:

(a) The certificates of the cause of death on which they are based do not necessarily show the fact of pregnancy or confinement.

(b) The selection exercised by the statistician classifying deaths, where the certificate shows more than one cause, may lead to a group of cases being included in one report as puerperal while in another the same group is ranged under a non-puerperal heading.

(c) The death rates are based on births instead of pregnancies. "Births," though their number might be proportional to the number of pregnancies, do not show the actual number of women involved, and no allowance is made for stillbirths and miscarriages, nor on the other hand for multiple births.

5. Of these sources of fallacy the first and second may invalidate comparisons between one area and another, but should not invalidate year by year comparisons for the same area. The error due to basing death rates on births is in the opinion of the Registrar General for Scotland of small moment, and may probably be discounted.

The more frequently comparisons of statistics have

[13] Report of the Scottish Departmental Committee on Puerperal Morbidity and Mortality (1924). Published by His Majesty's Stationary Office, Edinburgh, p. 2.

[14] The figures relate to paragraphs as numbered in the Scottish report.

arisen during the period of this study, the more profoundly have I come to distrust all such comparisons.

However, the facts connected with the birth of children, wherever studied (unless there is an income large enough to secure the attendance of a skillful obstetrician), admit of no other conclusion but the necessity for a safe attendant, other than the busy general practitioner, for normal childbirth in any community which has undertaken to provide a reasonable public health program. Such attendants may be called accoucheuses, midwives, obstetric assistants, or maternity nurses; the only essential is that they should possess the education which would make them equal to attending normal confinements. But whatever they may be called, the need for them seems to be a matter which cannot be questioned. Moreover, the need is not a temporary one; it has always existed and will always do so.

Therefore, like all other matters forced into the modern program for public health, the matter of providing a safe attendant for normal childbirth demands attention. When one has reached this point, certain questions arise: What type of attendant ought this person to be? How shall such attendants be educated, registered, and controlled? What will be the effect upon our present organization for public health and upon the private practice of doctors? How will the cost of this service be provided?

Following immediately upon the recognition that maternal care is a part of the public health program comes the question of the reduction of infant mortality in the very early weeks of life. In England the deaths per 1,000 births for the years 1918, 1919, 1920, and 1921 were as follows:[15]

[15] J. S. Fairbairn, *op. cit.*

Year	Deaths per 1,000 Births	
	Under 1 year	Under 4 weeks
1918	97.16	36.50
1919	89.13	39.79
1920	79.93	35.18
1921	83.0	35.26

The ideal towards which England is working is that all women shall be supervised during pregnancy and shall be provided with an attendant capable of conducting normal delivery and of being trusted to observe surgical asepsis throughout confinement, to send for a doctor when the need arises, and to give proper care during the postpartum period. To this end England spent in 1922-23 the sum of £1,725,263, of which £1,500,000 was given in unsupervised cash payments under the National Health Insurance Act.

In New York City about 105,000 babies under one month old die every year, while an equal number are stillborn; the majority of the stillborn are reported to be at term. This high and persistent early mortality is, according to a recent report of the Public Health Committee of the New York Academy of Medicine,[16] "almost entirely due to antenatal and intranatal conditions, and therefore largely preventible by better midwifery; it is a serious indictment of obstetrical practice that so little improvement has been made, and it must be

[16] "The Hospital Situation in Greater New York." Report of a Survey of Hospitals in New York City by the Public Health Committee of the New York Academy of Medicine (New York, 1924), p. 317.

the earnest endeavor of the new generation of practitioners to effect this belated advance."

To make a confinement safe, a doctor who possesses special knowledge of obstetrics and a woman who possesses special knowledge of normal delivery are necessary. The midwife and the doctor should not in any sense be rivals. The supervision of pregnancy should mean examination by a doctor and supervision by a midwife who may report to the doctor. In order to secure this relation between doctor and patient, there should be a retaining fee for the doctor and a regulated payment for the midwife. The case will then be conducted under the direction of the doctor, who will not choose to be present unless something out of the normal happens.

Many difficulties in the situation with regard to maternal care in England would disappear if the social and economic status of the midwife could be made as suitable to her position as that of the practicing doctor is to his. This Denmark has accomplished after an experience of nearly two hundred years.

Doctors must spend so long a time and so much money in preparation for their profession that they are too valuable to the community to be wasted upon any function that can be efficiently performed by another attendant. When, as in Denmark, normal confinement comes universally under the charge of such an attendant, social confusion disappears and the skilled obstetrician undertakes only intricate cases of abnormal labor with a midwife as his valued assistant. Danish doctors recognize that midwifery, in this sense, is as much a nursing function as giving a temperature bath to a typhoid patient or assisting with a surgical dressing. It is certain that one essential for the mother in childbirth is perfect

calm on the part of her attendants—a calm impossible to the overworked practitioner, who may be obliged to come in and out many times during the course of the labor. Nursing care of the mother is necessary to insure her recovery from the dangers of childbirth. In families where there is neither nurse nor midwife this constitutes a serious problem.

A doctor is frequently placed in a difficult position, because the patient and her family demand that he use forceps in order to relieve suffering. "Doctors yield to this demand too early and too often, and gravely deleterious results will follow," as the report of the Scottish Departmental Committee has it. Through prenatal care and better cooperation between doctor and midwife we "may reasonably look for the reduction of the number of cases in which forceps may be used injudiciously." [17]

Finally then, the English statistics fail to establish any very startling decrease in maternal mortality in the past twenty years, but it is possible that the figures do not show all the facts. The death rate can be reduced, and prenatal care is the most hopeful means of attaining this end. In general, the chief causes of death are (1) sepsis, (2) hemorrhage and accidents of labor. One reason for these deaths is the too general and injudicious use of forceps, while another is the practice of ignorant, uncertified midwives who have not even yet been eliminated from all districts. Even though there is little lowering of the rate of maternal mortality, midwives and doctors are both necessary to reduce preventable deaths and to prevent unnecessary and prolonged illness with its accompanying economic loss.

[17] Report of the Scottish Departmental Committee on Puerperal Morbidity and Mortality (1924), p. 20.

If doctors and midwives undertook a greatly extended and better coordinated prenatal service it would show substantial results. To this end and for other reasons, better education is needed both for medical students and for midwives. With better education of the midwife, a higher social position and earning capacity are inevitable; and with an improvement in the education of the doctor must come better cooperation with the midwife and the elimination of the pernicious rivalry now existing. When the economic and social status of the midwife is raised, her employment by all doctors as assistant in maternity cases will naturally ensue.

In certain parts of rural England an efficient plan has been established by which a safe attendant in childbirth seems to be assured for every woman. When public opinion has reached the point where every woman in these counties sends, as a matter of course, for this safe attendant, and when cooperation between doctor and midwife is better, the maternal death rate, which is already low in these localities, will probably drop to the irreducible minimum. The characteristic features of this successful plan are: coordination of all community health services under the County Council, with active cooperation of Queen Victoria's Jubilee Institute for Nurses, and the employment of two grades of nurses who are also midwives.

Finally, even though the excellence of the midwife's technical training is unquestioned and her skill in delivery is great, unless she becomes an ethical factor in community life and maintains the traditions of service established by doctors and nurses, she is bound in any country to be a source of evil rather than of good.

CHAPTER VI

EDUCATION OF THE PUBLIC HEALTH NURSE

TO EDUCATE a public health nurse to carry out all the functions of her calling in a creditable manner is not an easy task, and it has not as yet been accomplished to anyone's satisfaction, least of all to that of the public health nurse herself.

The hospital school of nursing does little to fit the public health nurse for her work. It is only recently that schools of medicine have made even a beginning of teaching medical students the principles and practice of preventive medicine, so it is not surprising that the schools of nursing are not yet ready to prepare young women for the branch of nursing into which so many of the graduates will certainly go.

But it has been found, after a period of experimentation with various short-term courses for public health nurses, that success in health teaching requires the thorough and fundamental knowledge of sickness and the skill in dealing with patients which the regular nurse training course alone can give.[1] Every woman contemplating a career in public health nursing must therefore begin her training as a member of a class in some recognized school of nursing. For this reason the question

[1] For a further discussion of this subject the reader is referred to *Nursing and Nursing Education in the United States.* Report of the Committee for the Study of Nursing Education. The Macmillan Co. (New York, 1923), p. 455.

of the education of the public health nurse involves a consideration of the whole field of nursing education.

The following observations on the present status of nurses and nursing service were recently made by one who sees present difficulties clearly and at the same time is hopeful of the future.

She [the nurse] plays an essential part in organized public health work; she is indispensable in the teaching hospital. And just now she is a storm center. Discussion, animated, sometimes excited, busies itself with questions of her training, qualifications, fields of work, hours, pay, motives, attitude. Physicians complain that she is hard to lure to the bedsides of private patients, that she is too often overtrained in theory, unduly professionalized, lacking in practicality and docility. Families find fault with the amount of her salary, the limitation of her hours, and her unwillingness to lend a hand in domestic tasks. Few people of modest means can afford to have her at all.

The hospitals, too, cherish a grievance. They give her a sound training only to see her desert the wards to do public health nursing, school nursing, industrial hygiene work, and the like. Some of the smaller hospitals especially are quite bitter about this exodus. One of the most frequent complaints has to do with educational requirements. These are declared to be uselessly high, too theoretical and professional, and a chief cause of keeping numbers low and costs high. All the plaintiffs tend to picture the nurse as something of a profiteer who has lost the Florence Nightingale spirit of sacrifice and service.

What has the defendant, the graduate registered nurse, to say about these indictments? Here are some of the things she believes ought to be considered. Her education has cost her time and some money—actually a substantial sum if what she might have been earning in other work is taken into account. After an elementary school course, and often one or more years of high school, she has spent three years in a hospital. She thinks that during her period of training the hospital had a good deal of work from her on fairly cheap terms.

When she has finished her course she feels that she has the right to choose between continuing in hospital service and entering the fields of private nursing or salaried public health or institutional nursing.

From this point she can hardly be described in the singular. A good many nurses fall into hospital routine and remain in spite of often rather irksome conditions of work, residence, and discipline. They cannot agree that the pay is excessive when their hospital duties and responsibilities towards pupil nurses are fairly appraised. Large numbers take private cases although there are disadvantages in living in families, in periods of unemployment, many times in a sense of being ineffectively utilized or even superfluous. Here, too, the actual income does not lead to affluence, when time lost, vacations, necessary expenses, insurance, and saving for old age are taken into the reckoning.

It is not strange that alert young women with initiative, imagination, and a liking for responsibility tend in growing numbers to enter the field of salaried public health service. Here they find continuous income, fixed hours, independence in personal living, and the satisfaction of giving well-organized aid and protection to large groups of needy and appreciative people. As to the Florence Nightingale spirit, the nurses admit that they are human, are influenced by the standards of living, dress, recreation, conduct, and personal ideals of their environment. Yet they are sincere in believing that in the mixture of motives by which they are actuated there is a steady current of sympathy and of loyalty to a high purpose. If they lack something of the devotion of the religious orders, it seems only fair to point out that society has not provided modern nurses with what these orders guarantee, support for active life and an old age of peace and security.

As in every case of clashing interests each group seems justified from its own standpoint. Attempts to fix blame lead as usual to more heat than light. Certain facts emerge more or less clearly from the turmoil. . . . The cost of private nursing service is prohibitive to people of small, or even moderate, means. Hospitals, especially the smaller ones, have more and more difficulty in recruiting pupil nurses and in retaining com-

petent graduates. Nursing service is too uniformly standardized to be used effectively and economically. Acute and complicated aid is the primary need, with some incidental and simple attendance on the sick. But it must be made reasonably attractive to suitable types in competition with other opportunities which society has to offer.

Fortunately, committees are beginning to study the problem with open-mindedness and good will. They are making studies of the actual facts; they are considering the classification of nurses into three or even four kinds with appropriate training for each; they are discussing changes in the curriculum, better and more economical organization of nursing service both in the home and in the hospital, the more effective utilization of public health nurses, and means of making the nursing career more desirable. . . .

Whatever is the solution of the nursing problem, one thing seems certain. There will, in any event, be a need for able and thoroughly trained women as administrators, teachers, and supervisors. The rank and file may include distinct grades, e.g., registered nurse, household nurse, even aide or attendant, each appropriately prepared; but the officers for these privates must have superior and special education.[2]

Conditions in Nurse Training in the United States

There were in the United States in 1926, 2,155 schools of nursing, with a total enrollment of 76,527. The graduates in that year numbered 17,522. There were 368 student nurses in twenty-four university schools of nursing which give a five-year course leading to a degree. Fifty-two of these students were granted degrees in 1926.[3]

[2] The Rockefeller Foundation. "A Review for 1925," by George E. Vincent, President of the Foundation, pp. 34-38.

[3] "Hospital Service in the United States. Sixth Annual Presentation of Hospital Data by the Council on Medical Education and

A study of the nursing schools of the United States is now being made by a Committee on the Grading of Nursing Schools, which is composed of doctors, nurses, persons whose primary interest is education, and representatives of the general public. Commenting on 1,500 schools already studied by this committee, the director of the study writes that more than one-third of these are connected with hospitals having a daily average of less than fifty patients, two-thirds with hospitals having less than one hundred patients, and 471, or less than one-third, with hospitals having more than one hundred patients.[4] In some of the European countries, particularly the Scandinavian group, an average of one hundred patients is required as a minimum for hospitals attempting to maintain registered nursing schools. A service admitting from sixteen to twenty patients per bed per year is an active service; below eight per bed per year is an inactive service. The Council of Medical Education for the American Medical Association urges that hospitals, to be satisfactory for the teaching of medical students, should have at least one hundred beds and an average of seventy-five or more patients.[5]

The Grading Committee discovered early in its investigations a startling difference between nursing schools and schools of other types. A typical nurse

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Hospitals of the American Medical Association." *Journal of the American Medical Association.* (March 12, 1927), pp. 789, 791, 793.

[4] "Problems Involved in the Grading Program," May Ayres Burgess, Ph.D., *American Journal of Nursing,* (December, 1926), p. 223.

[5] "Hospital Service in the United States. Sixth Annual Presentation of Hospital Data by the Council on Medical Education and Hospitals of the American Medical Association." *Journal of the American Medical Association,* (March 12, 1927), p. 825.

training school, a statement of the committee reads, has but one full-time teacher, requires of its candidates but one year of high school work, has but twenty-eight students, is attached to a hospital having a daily average of sixty-five patients, and exacts fifty-six hours of work a week from its students. After reading so far it is not surprising to learn that although the superintendent of nurses at this institution has occupied her post only two years she has just presented her resignation.

There is throughout the United States a large turnover among the head nurses in hospitals. This is most unfortunate for the student nurse, inasmuch as she necessarily receives her deepest impressions of nursing ideals from the head nurse whose example she has constantly before her. An equally great turnover occurs among directors of schools of nursing, who hold also the position of superintendent of nurses in the hospital. Here the average time a position is held is two years. There must be more than one reason for this condition, and perhaps the Grading Committee may be able to point them out. In England the ward sisters, who correspond to our head nurses, stay for long terms, ten or even twenty years being not uncommon.

In the schools I have visited the turnover among the head nurses seemed to be the result of the following conditions: (1) the salaries of these nurses are small, (2) there is little prospect of increased compensation with long service, (3) the introduction of trained teachers for student nurses on ward duty has taken away from the head nurse one of her great interests, (4) her prestige in the school faculty has suffered, inasmuch as instructors are usually paid salaries higher than hers.

Medical progress has multiplied not only nursing duties, but other procedures which must be carried out in hospital wards. Nurses are trained to do the work of technicians in many lines; for example, in one hospital visited a nurse had been made permanent technician for the cardiograph room, while student nurses gave considerable time to the preparation of ward patients for cardiographing. In a hospital connected with a school of nursing, blood pressure was being taken every half hour during the day following a surgical operation. Nowadays there are many patients who must be weighed daily; the collection of twenty-four hour specimens of urine are ordered for many more patients than in the past; and special diets require infinitely more time now than ever before. These are only a few of the additional routine technical proceedings which must be carried out by some one. In England it is more often the medical student who is charged with some of these tasks, while in this country they most frequently fall to the student nurse. Perhaps if such duties were properly adjusted to the nurse's practical program they would be valuable to her education. As it is, one often finds that while they have been multiplied to an almost overwhelming number, the standard of personal care of the patients has been lowered. It is most unusual to find that the budget for salaries of permanent graduate nurses to staff the wards is made larger in order to permit the same degree of nursing care in spite of the time-consuming technical proceedings which the student nurses have had added to their daily practice routine. The bed patient needs a daily bath, but on my recent visits such a standard of personal care was rarely met with. For

instance, in one hospital where $6,000 for staff salaries had recently been cut from the budget, the routine of daily care for the patient includes a full bath only every second day, and this is as high a standard as it is possible to maintain, since each student nurse must be responsible for the entire personal care of 4.2 patients.

Present-day methods of educating the nurse are wasteful and, to a certain extent, unwise. The director for the Committee on the Grading of Nursing Schools, in an unpublished report to the Committee, points out the defects of our system as follows:

> Hospitals, doctors, and nurses exist for the service of the patient but at present there is little concerted action amongst these three groups. Without wholehearted cooperation between the three we cannot hope to get at the roots of those evils in nursing education which impede progress in our health programs today.
>
> *The supply of nurses.* This is too great for the demand. Twenty thousand new nurses enter the profession each year; there are 200,000 in active practice; there are fifteen nurses for every ten doctors; there are 118,000,000 people in the United States; one out of every 590 people in the United States is an active graduate nurse. If the present trend continues, within the next seventeen years there will be nearly 38,000 nurses graduating every year. Where is the saturation point?
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> *Public Health Nursing.* There is no shortage of registered nurses to make application for the many public health nursing positions which are vacant, but the *quality* of applicants is not good enough to make them available; out of 108 public health organizations studied there were more than five applicants for every vacancy filled in the month of March, 1926.
>
> *Institutional Nurses.* Girls in their early twenties, with no graduate experience at all, are frequently given full responsibility for administering a hospital and conducting a school of nursing. It seems safe to predict that so long as present conditions continue there will continue to be a shortage of ade-

quately prepared nurses for the more important institutional positions.

Floor Duty. Until recently hospitals have had difficulty in securing graduate nurses for floor duty and even now it is difficult.

Private Duty. There are 20,000 new nurses coming into the profession this year. Of these 14,000 or more will start immediately into private duty. Two years ago there was serious unemployment. Last year it was more serious still. There is a current belief that nurses refuse calls, but there is little evidence that calls are actually unfilled. For those registries where separate figures are available, 96 per cent of all home calls and 99 per cent of all hospital calls were filled by nurses sent from the registry. It appears that only two patients out of every hundred are unable to get a special nurse when they want one. There seems to be a shortage of nurses *adequately prepared* to give high-grade nursing service along modern lines to contagious, mental, pediatric, obstetrical, and many types of medical patients. There is a serious shortage of nurses who have had graduate courses in teaching, supervision, or administration, such as would fit them for the more important positions in hospitals and public health organizations.

Practical or untrained nurses frequently charge more than registered nurses. The average pay of a practical nurse is $5 a day and that of a graduate nurse $6. The graduate nurse in a private home works 12 hours a day, at 50 cents an hour. A charwoman works 8 hours at 50 cents an hour plus carfare. Graduate nursing is so near in cost to the lowest level of unskilled female labor that the attempt to reduce cost still further by lowering the quality of the nurses seems obviously futile.

Physicians familiar with the practical aspects of the problem have suggested as a means of lowering costs a wider use of visiting and hourly nursing, and public funds for nursing in rural areas, and, most emphatically, a decisive change in hospitalization which shall so improve the quality of nursing service in the hospitals that the middle-class patient can secure proper care without being required to hire his own special nurse. What these physicians are urging is not a reduction

in quality but rather an improvement in quality and of more economical distribution. Requirements for entering the nursing profession today are not as high as for entering the commercial or business world. Nurses are being placed at about the same level as the factory worker. One often hears it said that "Some of the finest nurses I know never went beyond the grades," which is quite true, and is probably true of some of the finest of our older doctors. Those same men and women are the very ones who today are sending their young relatives to college. Among nurses who have been graduated from nursing schools within the past five years, 6 per cent have never been beyond the eighth grade; in public health, 6 per cent, and in institutional work, 5 per cent.

Who Heads the Schools. There are 2,286 schools for nurses in the United States. Almost all of them are controlled by hospital boards of trustees. They offer courses of from two to three years to young women who will give their services in return for instruction and a small monthly allowance. After a three or four months' preparatory course, these student nurses give from eight to ten hours a day, six days a week, to the actual bedside care of patients. This practical bedside and room experience is supplemented by regular courses amounting on the average, to not much more than thirty minutes a day; since it is at the bedside, not in the classroom, that most of the students' skill and understanding are gained. With hardly any exceptions, the head of the school is also the superintendent of the nursing service, and, since the board of trustees is primarily interested in running the hospital, it is her ability as an administrator, not as an educator, which determines whether or not she can retain her position.

How It Started. Fifty years ago, outside of the religious sisterhoods, the nursing service in most hospitals was unspeakably bad. Women were taken from prisons and alms houses to wait upon the sick. Within the short span of half a century all of this has been changed. Today hospitals are proud of the quality of nursing service they provide for even the poorest patients. The change has come about because hospitals started schools of nursing; and they started them not in order to substitute student service for graduate service,

because in those days there was no graduate service available, but rather to substitute student service for the service of so-called practical nurses. It was the wise, far-sighted, socially-minded hospital which first started the school of nursing. The nurse-training school was almost too successful. Had it cost a little more and worked a little less well, had the pioneer nurses who threw themselves into the task with such invincible enthusiasm and determination been a trifle less self-sacrificing and a bit more intent upon reasonable working hours and adequate budgets, it is probable that the nursing profession in the United States today would be smaller, healthier, and considerably happier.

Fewer and Better Schools. Nursing is growing more rapidly than the population. It is growing far more rapidly than medicine. At present there are apparently about 130,000 doctors in the United States and about 200,000 nurses. Reduction in number of graduates can only come when many of the largest and best known schools in the country consciously decrease the number of students whom they are training and consciously increase greatly the number of graduate nurses whom they employ on general floor duty.

The Problem of Costs. The cost studies, to be significant, must probably be founded upon an intensive and skillful analysis to answer such questions as, What kinds and amounts of nursing care do our patients really need? What are they actually given? Are expensive workers doing tasks which cheaper workers could do as well? Are cheap workers doing tasks which should be done by expensive workers if the patient is not to be sacrificed? Which is cheaper, a maid or a student? Which is cheaper, a student with detailed supervision or a graduate with little? Which one is sick more often? Wastes more food? Wastes more gauze? Uses more laundry? Breaks more instruments? Whenever hospital people get together, one hears discussion concerning the relative costs of conducting hospitals with schools and without. The shift from student service to graduate service is apparently coming fast. There will then be open to graduate nurses a great new field of employment—that of general floor duty in hospitals. The number of graduates coming into the profession will decrease.

The numbers of positions open for graduates after they are in, will increase. There will be a large supply of experienced and interested graduate nurses on which to draw for floor duty and there will be promotions from the ranks of floor duty nurses to higher administrative positions. Floor duty will become the training field in the hospital administration. If graduate nurses can be stimulating as workers in public health is it not reasonable to suppose that they might also be stimulating when doing hospital nursing? If superintendents and supervisors could concentrate all their intelligence upon learning what seems to be the extremely difficult technic of hospital graduate nurse administration, so that nurses will be happy and growing in their work, it seems reasonable to believe that full graduate service would ultimately be found very superior to student service. In many parts of the country thoughtful nurses are beginning to try out new methods in the administration of graduate hospital nursing staffs. This new movement away from student service and into graduate service may perhaps bring about a new and better adjustment for the nursing profession, in that it will make it possible for superintendents of nurses to achieve professional distinction without necessarily attempting to be educators.

Nursing for the Middle Class Patient. The problems which the hospitals face in adjusting themselves to the new demands upon them are primarily those relating to cost and personnel. With the steady shift of sickness out of the home and into the hospital, costly technic of medical diagnoses and treatment have been brought within the reach of the patients of every class. They share the doctor's time so that he can see many patients where formerly he saw only a few. This sharing of medical care in the hospital helps to bring the cost within the reach of the patient. "Why then," ask the physicians, "does not the hospital make similar arrangements for the sharing of nursing care? Must the patient hire a full-time, special nurse in order to be comfortably cared for, when a part-time graduate nurse's service at less cost per patient could do the work as well?" If hospitals were to provide intelligent, well-bred graduate nurses on general duty in sufficient numbers so

that they would have the time to do good nursing, physicians and patients would stop employing "specials."

The members of the grading committee are impressed with the fact that the nursing, medical, administrative, and trustee groups often have radically different concepts, not only of what each group is trying to do, but of what it is actually doing. It is probable that an analysis of the nursing care which hospital patients actually, not theoretically, receive would astonish everyone, including the nurses. The grading committee has already gone on record as follows: "The fact that a hospital is faced with serious financial difficulties should have no bearing upon whether or not it will conduct a school of nursing. The need of a hospital for cheap labor should not be considered a legitimate argument for maintaining such a school. The decision as to whether or not a school should be conducted in cooperation with a given hospital should be based wholly upon the kinds and amounts of educational experience which that hospital is prepared to offer."

Study of a Typical School Connected with a Large Hospital

The following is not a description of any existing school of nursing but of conditions typical of many schools accredited by state boards of nurse examiners. Such a typical school may be listed somewhat as follows:

Bed capacity	275
Daily average of patients	200
Number of registered nurses on duty	20
Number of resident instructors	1
Number of student nurses	85
Entrance age (minimum)	20
Entrance educational requirements (minimum) 4 years of high school work	
Number of months in the course	36
Number of hours on duty a week	52
Offers all services but tuberculosis, *i.e.*, medical, surgical, obstetrical, children, mental, contagious.	

Perhaps the most startling feature to be observed in the hospital wards is the absence of a graduate staff to stabilize the nursing service. It is pretty generally recognized now that such a graduate staff is needed, quite exclusive of the head nurse and her assistant. A school of nursing cannot in any degree meet present-day requirements without such a stable staff. In many hospitals there is not even a graduate nurse assistant to the head nurse. The head nurse is frequently the *only permanent paid graduate* assigned to the ward. It is not uncommon for this one sole graduate, the head nurse, to make rounds with the house and attending doctors between four and five hours out of her working day of eight hours and twenty minutes. This leaves her three hours and twenty minutes for (a) all her executive duties, (b) housekeeping, (c) charts and order book, (d) visitors, (e) interruptions. It is small wonder that two young head nurses should have told me naïvely that it seemed too bad that they could not get the pupils in their wards together during the daytime to tell them something about the needs of the patients they were nursing. One of these nurses went on to say that she herself had become greatly interested in the physical and mental condition of patients under her care since she returned to the hospital to take a paid position. "Of course," she said, "while I was a pupil nurse I couldn't know much about the patients. If a pupil nurse is at all conscientious she must spend every minute of her time on duty in trying to get through the ward routine. She cannot stop to learn about the patients' mental or physical conditions. There isn't a minute to read histories, question doctors, or learn about the patients from the

head nurse." An appalling state of things but quite inevitable while each pupil carries the heavy routine involved in caring for so many individuals. A ward patient is scheduled for two baths a week. I was told more than once that if he got one bath a week the nurses were doing well.

The pupils' working day in the wards runs from 6:45 to 6:45, with two hours off, and one hour and forty minutes for meals, leaving eight hours and twenty minutes of actual work. If there are as many as three class periods one hour of the allotted two hours of free time is cut off, but two class periods are taken out of the eight hours and twenty minutes of working time.

The routine is strikingly similar to that of twenty-five years ago, and the number of the nurses and their assignment to the various ward duties are also similar. The chief difference seems to a visitor to be that somehow, in an intangible sort of way, *nursing* appears to have become less and less evident. The hospital, now utilized for teaching medical students, is traversed constantly by young men and women who are busy with the patients much of the time. The head nurse—so much the hostess of the ward in the old days—is so occupied with "rounds" that she seems to be very little in evidence and to have a curiously lessened influence on the patients. The tone of the ward no longer seems to depend on her. These "rounds" themselves to which she gives so much of her time seem to have been, again in an intangible sort of way, divorced from her. "What have you observed? What do you suggest? What methods do you trust in relation to this patient?" were common questions to be put by an attending doctor to a head

nurse in the old days. It is not of any importance to the doctors of today—or so it seems to a visitor—to enlist the interest of the nurses in their problems, nor, on the other hand, do the nurses look to the doctors for help or sympathy in their part of the care of the patient. What has happened?

The typical school has about eighty-five pupils, but they are not all in the wards at any one time, of course, as the operating room, outpatient department, night duty, vacations, diet kitchen, and affiliations in four services take them away. They are sent to these services as follows:

Five to a mental hospital for 3 months.[6]
Five to a maternity hospital for 3 months.[6]
Two to the communicable diseases service for 2 months.
Two to social service for 2 months.
Two to a public health nursing association for 2 months.

The last three services are electives, so that out of thirty-six months in the course, eight may be spent in affiliations, leaving twenty-eight months, from which two in the entire three years (or three weeks a year) must be taken for vacations, so that but twenty-four months remain for all ward and other hospital services. One must also remember that time out for illness has to be reckoned with in the case of pupil nurses.

At any one time, then, there may be forty pupils on day duty, divided among all hospital services except that for private patients, and each pupil may have twenty-four months' hospital service.

In one hospital visited there were thirty-seven pupils on day duty, seventeen probationers on duty for a short

[6] All pupils receive this training.

time during the day, ten night pupils, six pupils in the operating room, two in the diet kitchen, seventeen in affiliating services, and three in the private patient building. An irregular number of pupils is sent to the private patient building, say three at a time. Unless the pupil is carefully taught there her time on that service is not educational.

As one goes about the wards one finds that the old method of giving a pupil nurse charge of all patients on one side of a ward and half of those in the extra beds in the middle of the ward still prevails, so that perhaps twelve patients to a pupil may be a fair estimate of her routine responsibility. She is, however, relieved to a certain extent for two hours early in the morning and again for a short time in the late afternoon when the probationers are in the wards. Now the manual labor of bed-making, dusting bedside tables, serving trays (the same heavy wooden trays of twenty-five years ago), cleaning utensils and lavatories for twelve patients is very exacting daily labor; and the more personal care of the patient, such as bathing, keeping the mouth clean, the back rubbed, the patient comfortable in many small ways must be got in somehow after the routine duties are done. The taking of temperature, pulse, respiration, the administration of medicines, other treatment, extra nourishment—all these routine tasks fall to the pupil, and not merely for so long a time as is required for the procedure to be well learned, but throughout the whole period of her ward service, since there is no one else in the whole hospital provided to do any of these necessary duties. In a forty-one hour week the pupil is indeed fortunate if she can give those two bed baths the patients

need, and one can readily see why she never has time to learn anything about the nursing needs of the individual patient. Recently I read this statement written by a clinician: "Medicine has become so much interested in the various functional and anatomical changes in the organs of the body that it has in some measure lost sight of the individual, the patient. The care of the patient as a whole has to some extent been handed over to the nurse." If this is true, what a pitiful state of things must result where the only nurses to care for the patients are so immersed in ward routine that they cannot thoughtfully consider the individual's needs at all.

The medical student is being excellently taught in the hospital today. The total crowding out of any opportunity to teach pupil nurses to care for their patients is by contrast, all the more disheartening. Think what it would mean to a nurse to have a patient assigned to her for study as the young medical student has. Such assignments of medical students to patients under the guidance and teaching of the attending doctor must give the young student a wonderful opportunity to develop any latent ability he may have.[7]

Student nurses no longer make medical rounds with the head nurse. There is no time for them to do so. I believe a thorough investigation of the actual number of hours of personal nursing care required by various types of patients is more important than any other study in nursing, at present. A beginning of this type of study has been made by Effie J. Taylor, superintendent of nurses of the Yale School of Nursing. The results of her investigation are summarized on page 183.

[7] In a few schools—and the number is increasing—just such a "case" method is being employed to teach nursing.

STUDY No. 1

Average number of patients estimated..... 250
Nursing care per patient per day, 2½ hours.
250 × 2½ = 625 hours per day
7 days per week

4,375 hours care per week for 250 patients

56 hours per week per nurse would require 78 nurses
52 hours per week per nurse would require 84 nurses
48 hours per week per nurse would require 91 nurses
78 nurses at $85 per month.....$6,630
84 nurses at $85 per month..... 7,140
91 nurses at $85 per month..... 7,735

STUDY No. 2

Study No. 2 takes three hours as a basis of nursing care per patient per day, with the following results:

56 hour week.....	93 nurses	$7,905
52 hour week.....	100 nurses	8,500
48 hour week.....	109 nurses	9,265

These are of course graduate nurses not being withdrawn from the patients for classes or any other purpose.

STUDY No. 3

Suggested minimum administrative staff for a hospital of 250 patients in 13 wards:

Superintendent of nurses	1	$3,000
Assistant to superintendent	1	2,400
Supervisors ($1,800)	2	3,600
Operating room supervisor	1	1,380
Operating room graduates	6	6,480
Head nurses ($1,080)	13	14,040
Night supervisor	1	1,380
Night assistants	2	2,160
Night operating room nurse....	1	1,080
	28	$35,520

These studies are interesting as a basis for comparing the typical hospital nursing service with the real nursing

needs of a patient. The estimated number of hours of nursing care required per patient, however, is low, four hours of such care being probably much more nearly what an adult patient in a public ward requires during twenty-four hours, while for children six hours is a minimum. One nurse to one patient in a children's ward is probably not enough in a hospital where medical research is continuously carried out, and this is entirely independent of administration and teaching (*i.e.*, the nurses who are teaching) staff.

An estimate of the ratio of patients to nurses, both graduate and pupil, has been made at Yale on the following scale:

Patients	600
Nurses	500
Of these there are	
Pupils	300
Graduates	200

This estimate includes all members of administrative and teaching staff as well as staff nurses. On this basis a comparison with numbers at a typical hospital is rather overwhelming. There the administrative staff consists of:

Director	1
Assistants to director	2
Instructor	1
Head nurses, including night staff	16
Total	20

Study No. 3 was exclusive of teaching personnel and

even so showed a minimum of twenty-eight officers. In a hospital with a nursing school there ought certainly to be an assistant to each head nurse provided in every ward. The worst of the situation in the typical hospital has not yet been described, for the duties imposed upon the director and her two assistants are not alone those concerned with the management of the nursing service and of the educational requirements of the pupil nurses. These women are responsible for engaging, directing, and dismissing all the servants and orderlies in the wards and in the private patient building. There are, on the average, twenty-four orderlies and thirty ward maids in the hospital wards and six orderlies and twelve maids in the private patient building. As the maids are paid only $35 a month if they live in the hospital and $45 if they do not, one can see what type of service theirs is likely to be and how much time must be given to managing them. Orderlies get $60 or $70 a month depending on whether they live in or out of the hospital.

At the time of my visit to one school a new class of eighteen probationers had recently entered. All were certified high school graduates. In age they ranged from 18 to 22 years, except for two who were much older—one 27, one 38.

It would have been interesting to have information about the families and background of these girls. The state blanks do not allow for this. Of the eighteen, two came from the Southern United States, four from Canada, and twelve from the Eastern United States. One had been a teacher and one had worked in an office. Seen together most of them appeared intelligent (one or two definitely *did not*) and interested to become nurses, that

is, interested in the idea of learning to care for patients. Watching them in one of their classes in anatomy, one gained the impression that under good educational conditions perhaps two-thirds of the group would be capable of learning and the others not, but such a judgment is of course superficial. The instructor's teaching was excellent; the girls were more alert at the end than at the beginning of the hour.

All the more depressing, then, was it to sit through her next hour with the intermediary class composed of pupil nurses who had been in the hospital a year. It was as if that year of hard manual work had closed their minds as tangibly as shutting a door. I do not mean that the work with their hands closed the door, but that working under pressure, with no one to help them to see and interpret the condition of the patients and their nursing needs, had had an appalling effect upon them. There were twenty-four in this class, a heavy, tired group. They were to have sixteen lessons in the nursing of medical diseases—a fascinatingly interesting subject and well taught by the instructor. But I had spent considerable time in the medical wards in this study, and I felt that the student nurses were missing almost every opportunity to learn about the needs of medical patients.

The quality of private nursing, too, is suffering. A private-duty nurse lives an anomalous life as to hours, promotion, holidays, time wasted in hanging about. Her life is perhaps less organized than that of any other professional woman and her free time more irregular. More than any other type of nursing, private duty demands the constant practice of virtues such as the patience and tact necessary to build up a vigorous, conscious coopera-

tion on the part of the patient. Unless the private nurse succeeds in doing this the doctor's task will be much more difficult. To practice nursing in this way there should be plenty of opportunity for private nurses to "take in" refreshment for their spirits. Association with people who are not sick, diversion, mental stimulus, opportunity to grow, are more necessary to a private nurse than to almost any other type of worker one can think of.

But the present organization of private nursing makes it practically impossible for private nurses to have any of these things. In consequence the better nurses will seek, and find, in hospital teaching or administrative positions or in public health nursing, a life which is not so stultifying. Something valuable and, at its best, very beautiful is being lost because the practice of private nursing remains unorganized and therefore does not supply those four essentials to a satisfactory working life: leadership, adequate pay, promotion, and proper working hours. As other fields of women's work are studied this one of private nursing in the United States stands out unique in its need for better organization.

A private patient needs varying kinds of care. Some of this can be better given by a really good maid than by anyone else, some by an attendant, perhaps; only a specified number of hours of nursing care should be required by any given patient. We do not know what the distribution of function and time in various types of cases is. Until we do, reorganization of private duty or of floor duty in hospitals cannot be accomplished. There is urgent need for study on these points.

In the typical hospital, staff duty in the wards is

shockingly inadequate. It is hardly an exaggeration to say that there is no nursing supervision of students in the wards. The students are responsible for almost all ward routine; they have practically no time to be taught the nursing needs of the patients and no one to teach them how to carry the responsibility of nursing patients if there was time for this. The time of the administrative staff is dissipated on tasks better carried through by some one else. The staff in the administrative office of the nursing service is wholly insufficient. A study of the duties of the director's assistant seems to show that only four out of sixteen of the functions she carries out ought to belong to her at all.

1. "Covering" office and telephone.
2. Interviewing applicants in absence of directress of nurses.
3. Visiting sick nurses with and without the doctor.
4. Keeping corrected list of nurses for telephone operators, elevator operators, laundry.
5. Carrying out orders for sick nurses.
6. Keeping up supplies.
7. Arranging for classes.
8. Posting class lists.
9. Chaperoning classes and examinations.
10. Dispensing uniforms to nurses assigned to social service.
11. Checking inventory of wards at end of each month for thermometers exchanged during month.
12. Keeping filled positions for maids, orderlies, and porters, and arranging for their vacations.
13. Submitting list for payroll twice a month.
14. Covering (partly) housekeeper in nurses' house in her vacation.
15. Covering (partly) instructor's work in her vacation.
16. Counting, sorting, and distributing to wards, one day during the summer, some 400 blankets from the cleaners.

The first four functions listed seem proper to a first assistant in the school. It would not seem important to differentiate among these duties if there was any provision other than through the administrative office of the nursing service for that constant intimate relation between the students and head nurses on one hand and the director of the nursing service on the other, but there is no such provision and the lack of it is apparent in the wards. There are no permanent nurses in the wards except the one head nurse in each ward. No one is thinking about the nursing needs of each patient, for no time is allowed for anyone to do so. The deadening effect on the student nurse's spirit and the stultifying of her mental processes is quite apparent if one studies the incoming class and compares it with the class that has been a year in the hospital. The average hospital has less than twenty graduate nurses to two hundred or more patients and eighty-five student nurses; and there should be at least twenty-eight permanent graduates exclusive of nurse teachers and administrative staff. The salaries of the graduate nurse personnel are far below the salaries commanded by good cooks and other upper servants in private families.

Summary.—The typical so-called nursing school is not in any true sense a school, since the time spent by the student nurses in the wards is devoted to a routine so exhaustive that they have no opportunity for any consideration of the nursing needs of their patients, and even if they had, that is, even if a graduate nursing staff should be employed to relieve the pressure now weighing upon the pupils, there would be no one to instruct in nursing for there are no nurse teachers or supervisors and only one instructor for eighty-five stu-

dents. The head nurse, the one graduate salaried nurse in each ward, has no time to teach and furthermore is not equipped to be a teacher. The internes, an invaluable though unofficial force in teaching nurses in the past, seem to have now little interest or indeed opportunity to help the student nurses to learn about their patients.

The service of the student nurses in the wards does not prepare them to be good nurses, except in so far as the routine of bed-making, dusting, carrying trays for meals, taking temperatures, giving treatments and baths, repeated many times over, in the sense of acquiring facility in these processes, may be said to be educational. And, from the educational point of view, the effect of omitting a patient's second weekly bath because the nurse must carry out twenty-four trays, dust twelve bedside stands, or take twenty-four temperatures in twenty minutes (since if she does not do these things no one else will), is bad. And the lectures, conferences, laboratory work, and practical nursing demonstrations do not counteract the effect of hours in the wards saturated with such service as this.

The average applicant for admission to the school of nursing is, on the whole, not a very intelligent or highly educated woman. She comes to be fitted, free of expense, for a life of private duty nursing, which is at present not organized so that it corresponds in hours of work, in promotion for good service, or in financial returns with other professional work for women. She is not a professional woman in background, the hospital "training" does not fit her for professional work, and the private nurse's life, into which she is apt to go, is not that of a professional woman.

The routine work of the hospital is done by its group

of pupil nurses at a cost probably little less than a graduate staff would cost. But the important thing here is this—it would be a poor group of graduate nurses who would for any long period of time be willing to compose such a graduate staff. Almost all the conditions surrounding the lives of such a permanent staff would have to be changed materially to attract and hold a good type of graduate to hospital duty in ward, private patient building, operating room, or elsewhere. A good school and also a good graduate nursing staff would cost much more than the hospital spends now on nursing.

The conditions described here make one wonder how it is that many hospitals continue to hold enviable reputations for giving good nursing care to their patients. That they do must be largely owing to the women who have administered their nursing services.

One crying need is for a committee concerned with the nursing service to meet regularly to advise with the director. There should also be an administrative committee of the school of nursing. The plan of so-called "group nursing" with its corollary to reduce greatly the number of special nurses is worthy of study.

The report of the Committee on Grading Schools of Nursing shows an oversupply of nurses of inadequate general education. It shows that, at the present rate of increase of nursing "schools" and of graduates from these schools there will be an alarming increase even over the present supply. Further, it shows that for each public health nursing vacancy five registered nurses apply but often not one of them is equipped to fill the vacancy. In view of these facts and others equally convincing it would seem unwise, even unjustified, for a hospital to maintain a school of nursing unless this is

properly organized, capable of turning out graduates useful to the situation likely to develop in the next ten or fifteen years.

Two distinct issues seem to present themselves: the nursing service and the nursing school. These ought not to be confused, nor ought they (as they now are) to be "fused."

University Schools of Nursing

Eighteen schools of nursing, recently visited, each connected with a university, present a variety of plans of organization and administration, which are so at variance that it seems more profitable to try to embody them in one story than to set down impressions of individual schools. Each of the schools recognizes that in order to educate young women in nursing there must be: (1) didactic instruction in classroom and laboratory, (2) technical training in a hospital or hospitals, and (3) a knowledge of health and of the social maladjustments that undermine it.

A university school of nursing should be an integral part of the university system, but frequently it is not accepted by the university as coordinate with other professional schools, and often it does not conform to the university standards. In some instances exceptions are made applying to tuition and preliminary education, and existing courses of study are modified to make them easier for student nurses. The dean of the medical school in one university, where there is also a school of nursing, says that a school of nursing is all too often attached to a university "much as a garage is attached to a house."

With regard to technical training in a hospital, there

is great deviation among the universities visited. One university permits the students to go to any one of a number of approved hospitals for their two years of practice training, after which they return for a fifth year at the university; and a degree in nursing may be given even though the two years of technical training cannot be evaluated exactly or measured according to university requirements. While this loose connection was sanctioned for the necessary practice training, one found, at the same time, the most complete identification of the nursing group with the undergraduate body of the university. The director of the school, who was studying for the bachelor's and master's degrees while carrying on her work, had been president of the faculty club, a mark of popularity indicating the pride taken by the university in the nursing group. There is no medical school at this university, but the premedical courses provide excellent teachers for the nurses; and laboratories, library, and classrooms are available. The weakness of the organization of clinical experience will in time be overcome, while the organization of the school of nursing as an integral part of the university and its undergraduate life could not readily be weakened. The president of the university hopes eventually to see a building on the campus which will house the school of nursing.

Another university, which is making a beginning in nursing education by offering a few nursing courses in connection with its school of social work, is already embarked upon an undertaking to influence the early development of schools of nursing throughout the state through adding to its faculty a secretary for nursing education, who will spend much of her time in travel.

One sees possibilities of a central school of nursing with a state university to control and guide it. While the status of the school of nursing within the university and its proper organization and financial basis present great difficulties, these are not nearly so serious as the readjustments necessary to raise hospital training to the standard required for the intelligent education of the student nurse. The oldest university school of nursing, that of the University of Minnesota, has completed an arrangement providing an inclusive and broad practice field in four hospitals; namely, the University Hospital, a small private hospital, the large Minneapolis General Hospital, and the Northern Pacific Hospital maintained for railroad employees. In all, 1,150 beds are available for teaching purposes, and the whole field is directly controlled by the University School of Nursing.

Mary M. Marvin in a recent article on the teaching of nurses in the hospital wards says:

> In each school three factors—environment, personnel, and time—must be considered in order to develop this work. The environment must be conducive to teaching, that is, there should be a sufficiently active service and good working equipment. The standards need be no higher than those required of any hospital that legitimately establishes a school of nursing.
>
> The personnel should consist of qualified supervisors, head nurses, and students with a good preliminary background. There must be enough help, consisting of nurses, attendants, orderlies, secretaries, or clerks to make it go. One might experiment a little in the beginning with an inadequate personnel and then one would know how to develop the plan.
>
> In the last several years, because of various unintentional causes, teaching in the wards has deteriorated. On the other hand, classroom teaching has increased in amount, improved in quality, and has thoroughly justified itself. Nevertheless, classroom teaching is not a substitute for individual case or

clinical study and never will be. Case study is one of the only ways of making the student see that each patient is a sick individual who has many outside connections, and it is one of the best ways of developing a nursing conscience.

There are some defects in the administration of the ward at the present time which seriously stand in the way of making it the best teaching laboratory in the school, although by its very nature it possesses many elements of an ideal situation. If the people directly in charge of this part of the school were impressed with the advantages which the right kind of ward teaching would bring about in the evolution of better nurses and nursing, and furthermore, if they were guided in improving their work, there is not much doubt that they would gradually assume their new responsibilities with eagerness and interest. Good results have been obtained here and there with some good incidental ward teaching, but what great success might be obtained if all those who can, would concentrate on the proceedings taking place where the students work with their patients, the most interesting, strategic, and vital teaching center of the whole institution,—the ward![8]

Evolution of Nursing Education

If conditions in nurse training leave much to be desired we must remember that nursing education had its beginning little more than half a century ago. Not until then was it recognized that certain preparation in addition to a "special calling to the field" was necessary to make an acceptable nurse. Of the private practice of medicine fifty years ago Dr. Abraham Flexner says:

> . . . the office of an able urban practitioner consisted of two rooms, one for waiting and the other for consultation. There was little to indicate which was which beyond the ancient tilting haircloth examining chair, the wash-basin never empty,

[8] *Methods of Increasing Ward Teaching and Improving Supervision,* Proceedings of the Thirty-second Annual Convention of the National League of Nursing Education (1926), p. 112.

with its pitcher never clean, the roller towel renewed at long intervals, a few simple instruments which, used for all sorts of purposes, were never boiled, two or three vials containing mercury or carbolic acid for local applications, and the mantelpiece strewn with proprietary preparations in dust-covered bottles. Urinalysis was employed—practically no other laboratory procedure.[9]

Since conditions were such at the time when we were beginning to give training in nursing, it is unreasonable to expect that a satisfactory system of education should have been evolved after the lapse of a few years.

Nurse training, according to M. Adelaide Nutting,[10] has passed through two distinct phases in its fifty odd years of existence, and is now in the third stage. *Service, association,* and now *education* are terms that may serve to characterize these phases. In the first period, that of service, Florence Nightingale was under the necessity of reforming many details of hospital management besides the actual bedside care of the patient. Ideas with regard to food, linen, supplies, and household service had to be completely reorganized, and if these things were to receive proper attention the nurses would have to take over the responsibility. It followed that manual service became incorporated in the nurse's training everywhere; she scoured and scrubbed, not because Florence Nightingale believed such tasks essential to her training, but because, in the beginning, it was necessary to ask nurses to do them in order to get them done at all.

This early necessity has produced a baffling situation, for everywhere throughout the succeeding fifty years

[9] *Medical Education,* The Macmillan Company (New York, 1925), p. 9.

[10] *A Sound Economic Basis for Schools of Nursing,* G. P. Putnam's Sons (1926), p. 299 et seq.

students of schools of nursing have formed the chief labor supply in the hospitals to which the schools are attached.

During the period of association, covering approximately twenty years, the entire nursing profession was organized and its efforts directed, in the main, towards the improvement of nurse training. It is quite recently that we have passed into the third stage of development, in which education in nursing has come to be considered from the same standpoint as education in other fields. We enter upon this third phase with urgent responsibilities and insistent demands pressing us forward.

Dean Goodrich of the Yale School of Nursing has pointed out that all of the nursing schools in a given community must of necessity work for a common end in at least three essential particulars: (1) needs of the field content of education, (2) sources from which to draw nurses, and (3) machinery to provide education.[11] The readjustments necessary to make the hospitals the laboratories of the schools of nursing and no longer the institutions which the schools of nursing serve are, in the main, no different from the readjustments being sought by schools and colleges on one hand and business at large on the other.

We have made some progress in our schools of nursing during the past ten years, but perhaps it has been chiefly in the direction of bringing to light the difficulties inherent in our present practice of nursing, rather than in any conclusive reform in the standards of nurse education. Not the least of these difficulties is a financial

[11] A. W. Goodrich, "A Plan for Centralizing Schools of Nursing," *The American Journal of Nursing* (1922), p. 548.

one. A recent report [12] on the cost of nursing education points out that separate budgetary systems for schools of nursing should be adopted throughout the country in order to do justice to hospitals maintaining proper standards in their schools of nursing to free them from the charge, so frequently brought, of exploitation of student nurses, and to enable hospital authorities to make application for a separate and extra proportion of funds assigned them through community chests, federations, and so forth, to be devoted to the exclusive use of the school of nursing. Furthermore, without separate budgets for the school of nursing one cannot bring clearly before the public the need for greater financial support and assistance to house and educate pupil nurses properly.

Fitting Preventive Nursing into the Nursing School Curriculum [13]

In all of the schools visited except that at Yale University there was uneasiness and uncertainty with regard to practical methods of introducing preventive nursing into the already overcrowded curriculum. In several schools a course in public health nursing exists side by side with the school of nursing, but not as an integral part of it. Indeed, it is sometimes in another department of the university.

The school of nursing is perhaps in the college of liberal arts and the course in public health nursing in the

[12] "Cost of Educating a Nurse," Sister Mary Ambrosia, *Hospital Progress,* July, 1927, p. 267.

[13] For full information on public health nursing courses in the United States, see *Public Health Nursing,* by M. S. Gardner, The Macmillan Company (New York, 1924), pp. 58-69.

school of social work. Under such conditions the department in which the public health course is placed has no influence upon the technical training of the student nurse. Quite unlike all the other university schools of nursing in this respect is the school at Yale, which is testing a plan combining bedside and public health training in one curriculum. Its aim is to develop a program of education which will make as important a contribution to the field of preventive medicine as did the earlier school of nursing to curative medicine.

The curriculum of the Yale School covers a period of twenty-eight months, the equivalent of three college years.[14] What is known as the "case method" of teaching is employed throughout the course.

The patient is the unit about which all thought centers, and the gathering of data connected with the patient calls the attention of the student to the patient as a member of the community and a member of a family with responsibilities to himself and to others which must be taken into account in his present, and what may ultimately become his future, condition.

Cases are assigned to students throughout the school in accordance with the following general plan:

The head nurse makes for the staff of her ward a program for clinical work for the week. All of the patients in the ward are divided into groups. Each student is assigned the care of one group and the relief care of a second group. In making out her schedule for the week, the head nurse alternates the time of each two students,

[14] The plan of organization of the Yale University School of Nursing is well described by Effie J. Taylor, "Teaching Nursing by the Application of the Case Study Method," appearing in the *Bulletin of the International Council of Nursing,* January, 1927.

so that one is on duty when the other is off. The clinical experience program is posted in the ward, so that any student can tell at a glance the group of patients for which she is responsible. She knows she will care for this same group until she and the head nurse feel that she has acquired the experience which these particular patients offer.

The student is asked to study each patient in her group and to make a plan for his nursing care. This plan, briefly outlined on a card, is submitted to the head nurse for suggestions and approval before being put into effect. It is attached to the patient's chart and is a guide to the care any patient is getting at any time, which may be conveniently followed.

One such plan made out by a student nurse took into account the fact that an arthritic patient who was unable to feed herself took so little interest in her food that it was hard to give her enough nourishment, also that she was very fond of listening to reading aloud. Another patient was enlisted to read to her while she was being fed by the student nurse, a plan which proved successful.

Each ward service is followed by two weeks of observation and assistance in the out-patient department, where social case study is made as important a part of the required routine as is the technical nursing connected with various clinics.

Through the Visiting Nurse Association and other health and welfare groups the case experience of the students includes, so far as possible, the follow-up work in the home. Thus the professional training of the student in the actual care of the sick is strengthened by a knowledge of the underlying theory in regard to disease

and also of the social, psychological, and hygienic aspects of the case.

If one were to set down the time, day by day or hour by hour, devoted in the Yale School to preventive nursing, it would amount to a considerable period out of the twenty-eight months' course. The public health nurse, having had a basic education organized on such a plan, should be equipped with that open mind which insures a continuous process of growth and development. Further experience she must certainly have but this she will seek and acquire.

Women who have completed two years of college are eligible for admission to the Yale School. The degree of Bachelor of Nursing may be awarded at the completion of the twenty-eight months. It is estimated that the aggregate cost to a student for the twenty-eight months' course leading to the bachelor's degree will not exceed $500. Since the opening of the school thirty-six nurses have successfully completed the course. The degree of Bachelor of Nursing has been conferred upon twenty-five and eleven have received diplomas qualifying them for practice as nurses. In general, one would say that there is an "atmosphere of thought" in the education of nurses at Yale such as is found in no other nursing school. The case method of teaching, absorbingly interesting as every student testifies, produces an attitude of mind unusual in the average student nurse. The Yale nurses appear to feel more interest in the comfort of the patient; and to an observer this seems to be because time is allowed for the individual study of the patient as a human being, who is, perhaps, not only physically ill at ease but anxious or preoccupied with responsibilities

and concerns abruptly broken in upon by illness. To understand the great significance of this enlarged attitude of mind, one must study the Yale school at close range. Young women of the present day who are choosing a profession will, one is convinced, be drawn to nursing and will pay for such education as is offered there, when once its method of teaching becomes generally known. In the group of student nurses at Yale one finds all that ardent young enthusiasm which women have always shown when the nursing appeal has been unclouded by confusing issues. Through utilizing all community resources for the care of the sick and the prevention of disease, and through correlating this essential field work with class work on a level with other professional education we should approach a preparation for public health nursing which would be greatly superior to any of the existing postgraduate courses now superimposed upon the usual nursing course.

An observer is impressed with the possibilities of an immediate reorganization of the out-patient social service departments of hospitals to the end that student nurses may be taught prevention in accordance with the Yale plan. More than $65,000 is being spent by one social service department visited, chiefly for salaries of well-qualified social workers. It is interesting to speculate how far an adaptation of the Yale method might utilize the student nurses to the mutual advantage of hospital and student. With the great diversity of organization it seems evident that each school must adapt its methods of teaching prevention to its own conditions and, with this in mind, the writer has wondered whether it would be profitable for certain leaders and teachers to

have opportunity for observation and study at Yale or at other schools where specific methods may have been worked out most successfully.

At the University of Toronto a new course [15] in public health nursing was opened in 1926. It is of four years' duration and is designed, from the first year to the last, to fit the student for public health nursing and for that one field alone. The entrance requirements are complete university pass matriculation, with honor matriculation in at least two subjects, one of which shall be English. No degree is given for the completion of this course.

Conclusions on Nursing Education

The outlook in nursing education is promising. Leaders in this field are trying to determine to what degree student nurses are being educated while on duty in the various hospital services. The College of Nursing in England, the National League of Nursing Education and the National Organization for Public Health Nursing in the United States, the Canadian Nurses Association, many nursing organizations in other lands, the International Council of Nurses at Geneva, all are uniting to bring about more intelligent training for the nurses of this generation so that they may be better fitted to meet the needs of a new day. The opportunity to develop a public health and social point of view in ward work is excellent. The opportunity to correlate theory and practice in ward teaching is unique, and in some hospital services there is good opportunity to tie up the ward work with that of the out-patient depart-

[15] "Course in Public Health Nursing," in *The Canadian Nurse,* (November, 1926, Winnipeg), pp. 585, 586.

ment. But "the interpretation of the objectives in nursing is often too narrow, and the whole growth of the student is sacrificed to the development of a few abilities which are convenient in doing up the hospital work." [16]

[16] M. M. Marvin, "Methods of Increasing Ward Teaching and Improving Supervision," Proceedings of the Thirty-second Annual Convention of the National League of Nursing Education (1926), pp. 108-109.

CHAPTER VII

THE FUTURE

IF IN 1919 we had set down our ideas of the probable status of public health organization in 1929 it is not likely that we could have given an adequate picture of the great developments of these past ten years. To look ahead is a fascinating occupation; to look ahead into the future of the community health program in this country involves so many administrative organizations and so many types of professional work that prophecy becomes peculiarly adventuresome. However, as I come to the end of this book, it seems evident that the foregoing chapters will be clearer and more interesting if they are considered in the light of such an imaginative future.

The nurse in public health (Chapter I) has become essential to teach health in homes, at clinics, in schools, and in industrial establishments. Since rural conditions make it difficult to provide proper facilities for health (Chapter II), the public health nurse is more needed in remote country places than elsewhere; but it is difficult to supply enough public health nurses for rural communities, first, because money for every purpose is scarce in the country and, second, because conditions of living and of working isolate rural nurses. In the United States there has been rapid expansion of public health nursing in cities and, particularly in the Eastern states, a tendency for privately administered public health nursing associa-

tions, such as visiting nurse societies and child welfare associations, to carry on work of the type for which in the Western states public health officers incline to assume responsibility. We are giving a good deal of thought (Chapter III) to the allocation of administrative responsibility for public health nursing work. Economy and efficiency urgently demand that we do so. To study the beginnings of a movement (Chapter IV) sometimes helps to make present and future clearer; and nursing as a profession is only just beginning to be introduced in some European countries. It is significant of the trend of our times that it is the public health program and the need for public health nurses which is stimulating the founding of schools of nursing in these countries.

Foremost, perhaps, in our thoughts as we plan for the future is the excessively high maternal mortality rate of the United States today (Chapter V). Public health nurses are deeply involved in our present community programs for maternal care. A study of their functions in this program in England offers helpful suggestions for an extension of our present program.

One cannot consider the nurse in public health as an isolated worker apart from other nurses engaged in other forms of nursing (Chapter VI). At this moment fundamental changes in nurse education occupy the attention of those most concerned in community health programs, for there are not enough well-qualified public health nurses to make permanent those public health activities the value of which has been demonstrated. Furthermore, it has been shown that present methods of educating public health nurses are wasteful and inadequate. As these methods are improved upon we may expect to see (1) the elimination of unqualified nurses, and (2) fun-

damental changes in living and working conditions in the field of graduate nurse practice.

From the School of Nursing at Yale a class of thirty-four young women will graduate in 1931. Into what conditions of work will they enter? What will the ten years following 1931 bring about? Like other young women intelligently prepared for a profession, they will expect to find opportunities to practice which will give them professional leadership, opportunities for promotion, reasonable hours and living conditions, and an assurance that the work they will do is needed in the community.

Just as public health nursing has gone through a period of standardization in the past seventeen years so, there seems reason to believe, will the other branches of nurse practice be organized to permit of such standardization as will produce a stability in private nursing, in floor duty, and in graduate executive positions in hospitals, so obviously lacking today. There are already seventy-nine reorganized nurses' directories in the United States. This new type of directory has been called a "cooperating nurses' center." So far little more has been accomplished in these centers than to recognize that cooperation is necessary to the success of any effort to change private nursing practice so that it will conform to other professional fields of work with regard to increased salary for special ability and experience, better working hours, and educational opportunities, so that there may be advance in professional skill instead of a static acceptance of the principle that, once graduated from an accredited school, a private nurse is "educated" for her work for all time to come.

Cooperation within the directory would mean a dis-

tribution of calls to cover holidays and Sundays, night duty, and emergencies, so that much of the present dissatisfaction and apparent shortage of nurses would disappear. Only one out of three nurses belongs to the American Nurses' Association, only one-ninth of the total number of nurses in the United States take the official nursing journal. Our alumnæ associations are little influenced by our local leagues of nursing education, for the reason that we are divided into three national associations—the National Organization for Public Health Nursing, the National League of Nursing Education, and the American Nurses' Association—and the struggle to be faithful to the demands of each one of these separate organizations becomes overwhelmingly complex and leaves no energy for concentration upon the common needs of all three groups of nurses.

When we have one magazine and one professional national organization with sections representing special interests, and when we have made a concerted effort to enroll the other two-thirds of our nurses as members of this association, we may look for better and more stable conditions in the profession of nursing.

Into such a future one's imagination makes adventurous flights. Nursing education will repeat the story of medical education: many of the nursing schools will disappear and with them many of the undergraduates of poor educational background. There will be less distinction between the three fields of nursing; for with the growth of hourly nursing, the visiting public health nurse and the private hourly nurse will come into a field so similar as to be indistinguishable. Furthermore, if "group" nursing in hospitals proves practical the highly individualistic private duty nurse will emerge to become

again more completely a part of the nursing service provided by the hospital for all patients. And under such a reorganized plan for "floor duty" the graduate nurse's experience and skill, personal qualifications for leadership and teaching, will open a field now closed to private nurses, inasmuch as the younger graduate and undergraduate nurses, who will be part of the personnel of hospital group nursing, will need direction. More graduate nurses in public wards, and changes in hours, salaries, and living conditions for this group, will perhaps be a part of this future organization and will have a tendency to bring back a certain atmosphere now lost in our hospital ensemble—an atmosphere which comes through better integration of nursing services.

In the city homes from which hospital patients come and to which they return there will perhaps be changes resulting from greater intelligence with regard to health and from better practical knowledge of the principles of home nursing. The fact that high schools have so generally introduced home nursing courses and that public health nurses are so much more generally accepted in the community will result in many common nursing procedures being carried on by the family. Already "health centers" have become to some extent and in some communities a source of direction for such home nursing care. In the case of families where incomes are large the establishment, sometimes maintained by a consultant in medical practice, takes, even today, the place of such direction. A dietitian is a member of such a consultation plant; specialists in several branches of medical practice may also be a part of it. Why not a visiting nurse to act as liaison officer between home and consultation room?

And in the rural communities small hospitals might, with the growth of health center activities, introduce similar programs involving visiting nurses who would undertake the direction of home nursing, correction of physical defects, and prevention of illness. Why could not a central nursing school for a whole state direct all the clinical nursing service in the small hospitals in rural communities necessary to the health of the people living there? Perhaps the future will show us how this will come about.

We do not know how the cost of medical care is to be defrayed in the future; but the bill for health is unpaid today; and the fact that it is unpaid, that we cannot put into effect those means now known to produce health, has stirred us to study and investigate, so that we may perhaps be more ready to answer this question in ten years' time than we are now.[1]

Today doctors and nurses are concerned with changing the perspective of schools of medicine and nursing so that the idea of health and the prevention of disease will become the basis of all work with patients and their families instead of representing an additional group of facts superimposed upon a fixed body of information dominated by pictures of pathological conditions of one kind or another. The natural sciences will come closer to the social sciences, and thinking health and teaching the principles of health will come to be the first preoccupation of doctor and nurse. Already leaders in the field of mental health have shown the way to this goal. It is not a desirable thing to live more days if they are not to be better days; but it seems possible to predict that the lengthening life span will carry with it so much more

[1] Committee to Study the Cost of Medical Care.

vigor to the individual that length of days will be worth working for.

Already we know that many more public health nurses are needed to carry through to completion our known-to-be-effective plans for saving life and making it possible for the lives thus "saved" to "see good days." We know that these nurses must be more in number and better in quality. The rural community needs more attention. The beginning of the cycle of life—maternal care—has been terribly neglected. Not only is there appalling loss of life in childbirth in the United States, but the ill-health resulting from poor care in pregnancy and at confinement is no less shocking because there is little statistical evidence to show how extensive it is. A study of the further uses of public health nurses may bring about changes in procedure which in the years to come will more nearly approach Denmark's methods, or those now carried on in the rural mountainous regions of Kentucky.

And if we permit ourselves to imagine these things, we must also see the general public becoming better and better informed and taking an active part in all community health work. As members of community health committees, laymen and laywomen will surely be more and more active in securing health legislation and the appropriation of public funds for health work, in extending health organization, and in developing plans for the education of the community in matters concerning health. For the keynote to all health activity is education, and this the public is learning to demand.

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