HOW CAN WE BEST SOLVE THE MIDWIFERY PROBLEM

CHARLES EDWARD ZIEGLER, A.M., M.D., F.A.C.S.
Professor of Obstetrics, University of Pittsburgh
Pittsburgh, Pennsylvania

Read before the Child Hygiene Section of the American Public Health Association at the Fiftieth Annual Meeting, New York City, November 15, 1921

MIDWIFERY STATUS IN THE UNITED STATES

ON the basis of the registration area (53 per cent of the total population), it is estimated that there were born in Continental United States in 1918, 2,664,685 babies, including 91,665 stillbirths (3.44 per cent). Of the babies born alive, 10 per cent died before the end of the first year, so that including stillbirths about 350,000 out of the total number born during the year, perished—that is to say, 13 per cent or 1 out of every 8.

Statistics (Howard) show that the stillbirth rate in the birth registration area is 60 per cent higher than that for Stockholm (2.16 per cent); that the rates for New York (4.38 per cent) and Philadelphia (4.39 per cent) are 35 per cent higher than that for Birmingham (3.24 per cent), and over 100 per cent higher than the rate for Stockholm.

As to maternal mortality, statistics show that during 1913 about 16,000 women died in the United States from conditions dependent upon childbirth; that in 1918, about 23,000 women gave up their lives in the same way; and that with the 15 per cent increase estimated by Bolt, the number during 1921 will exceed 26,000. Maternal mortality in this country when compared with certain other countries, notably England and Wales and Sweden is according to Howard "appallingly high and probably unequalled in modern times in any civilized country." And according to the same authority, these rates for the United States of 88.48 per 10,000 births (live and still) are on a par with those of Sweden 110 years ago; are 75 per cent higher than those of England and Wales 60 years ago; are 120 per cent higher than the rates for England and Wales in 1911-15; and exceed the rates of England and Wales for 1918 by nearly 75 per cent for puerperal fever and 150 per cent for all other affections of the puerperal state combined. Howard shows also that New York City's rate (46.11), which is much lower than that of any other American city, is 35 per cent higher than that for Birmingham (33.49).

According to Williams this condition of affairs has existed for a very long time—"for the last 50 or 75 years with comparatively little improvement." And this is not all. Polak is authority for the statement that "more than 61 per cent of all gynecologic surgery is the direct result of poor obstetric practice." Thus in addition to the awful mortality, immediate and remote, untold thousands of women are crippled and invalided and subjected to serious surgical operations each year as the inevitable consequences of childbirth under existing midwifery conditions in this country. The horror of the situation becomes apparent when it is realized that all but a very small percentage of this mortality and morbidity is inexcusable and preventable by the proper handling of obstetric cases, as may be seen from the practice of obstetric specialists the world over.

As early as 1875-77, in the Royal Maternity Charity of London, out of 9,019 deliveries of women in their homes, but 21 women died or 2.3 per 1,000 deliveries; in the work of the Maternity Center Association of New York City there were 9 maternal deaths in 4,496 confinements or an incidence of 2 per 1,000; and in the Pittsburgh Maternity Dispensary out of 3,384 confinements but 6 women died or 1.7 per 1,000 deliveries; and in the practice of obstetric

specialists, especially in hosiptals, maternity mortality is almost nil.

In this country we lose before the end of the first year one baby out of every ten born alive; whereas in New Zealand, with the lowest infant mortality rate in the world, but one baby in twenty born alive perishes before the end of the first year. What may be accomplished has been demonstrated by the New York Maternity Center Association where intensive prenatal care was responsible for a 50 per cent reduction in the number of stillbirths and of babies dying during the first month of life.

As maternal and infant mortality rates are the indices of the "social well being of a people and of the kind of care which its pregnant and lying-in women receive," it is evident that the United States occupies an unenviable position among the civilized nations of the world, seventeenth in maternal and eleventh in infant mortality.

THE PROBLEM—ITS NATURE AND SCOPE

The problem, as I see it, is to provide competent obstetric care for every childbearing woman in the country for what she is able to pay.

Ever since the days of Pasteur and Lister we have known how to prevent sepsis following childbirth. Statistics show, moreover, that our present-day knowledge of obstetrics is quite sufficient when properly applied in practice to eliminate all but a very small percentage of the maternal mortality and morbidity and to reduce the fetal mortality by more than one-half. The trouble is not that we do not possess the knowledge but that we do not use it.

Some years ago while passing through the wards of the Dixmont Hospital for the Insane near Pittsburgh, I was accosted by an inmate who insisted that he had a secret which he must tell me. Taking me aside, he whispered into my ear the information that he knew how to get rid of the typhoid fever in Pittsburgh.

I asked how he proposed to do it. He said. "With pure water."

I then asked how the pure water was to be secured. His reply was that he knew where Pittsburgh was and where the pure water was.

"But," I asked, "how do you expect to get the water into Pittsburgh?"

He replied. "That's the secret," and walked away well satisfied with his answer.

I followed him and after much urging finally secured the secret which he imparted with much gravity and again in a whisper, "Why, just build a big pipe line into Pittsburgh and let the water run through it."

And, why not? Why don't we stop talking about it and just do it? We have the knowledge in one place and the people we can help in another. The problem is to bring them together. It can be done; but the objection is that the pipe line costs more than we are willing to pay. Just so; and this means that the problem is a purely economic one.

The objects of childbirth and the results of childbirth are so intimately related to the social and economic welfare of the people that they become matters of grave public concern when opposed by destructive influences of such vast proportions that the individuals affected cannot withstand them. Each year in this country about two and a half millions of women—less than 2½ per cent of the total population—are charged with the responsibility of the nation's childbearing; each for herself and dependent solely upon her own resources must bear the physical and economic burden associated therewith. With what risk to her life and how fruitless and useless much of her burden-bearing is, we learn from the more than 2,000 maternal and 30,000 infant deaths each month.

We are told that 150,000 people die each year in the United States from tuberculosis—a rate of 150 per 100,000 of the population. We are appalled at the awful loss of life and economic wastage.

The whole nation is aroused and in every city, town and village in the land money is freely given and everywhere the cry goes up for help to fight the scourge, and very properly so. But a far greater scourge follows in the wake of childbirth which stands next to tuberculosis as the cause of death among women between the ages of 15 and 45. A conservative estimate places the number of infants born dead and dying during the first two weeks of life at 200,000 each year, of which at least 90 per cent are dependent upon causes having their origin in pregnancy or labor. Thus 200,000 women and infants die each year in the United States as the direct result of childbirth, a mortality of 200 per 100,000 of the population—a rate 33⅓ per cent higher than that from tuberculosis in both sexes and all ages. As it is not known what proportion of the population is exposed to tuberculosis, we cannot know the proportion of deaths to those exposed. On the other hand we do know that out of approximately 5,000,000 mothers and babies exposed, 200,000 die, a rate of 4,000 per 100,000 of the exposed—that is to say, 4 per cent or 1 in every 25 exposed.

This great loss of human life and the economic wastage dependent upon it are due to ignorance on the part of the people, and the economic impossibility of providing for the vast majority of women competent obstetric care for what they are able or willing to pay. The care which the average obstetric case requires is so great—so time and strength-consuming, and so exacting—that no physician can do the work, as it should be done, under existing conditions for the compensation obtainable. It is not so much a question of how doctors and nurses and others can be adequately trained for the work as it is a question of how to provide the funds necessary to make their services available. It will avail little to provide trained workers if the people through ignorance will not employ them or through lack of funds cannot pay them.

We might just as well be honest with ourselves and admit that the reason why there are not more trained obstetricians is that there is no demand for them. I care not how good the teaching in the medical schools, it will not raise the level of obstetric practice among family doctors unless the people are at the same time educated to employ them and to pay them a living wage. Every teacher in obstetrics has long since known this. Many of the doctors we send out from the medical schools do conscientious work for a time, but they soon learn that they cannot keep it up and prosper financially. Thus the more conscientious among them give it up, the others continue in the work putting as little time as possible upon it and accepting in the way of compensation just what they can get for it. The result we know.

We have reached the place where it is coming to be understood that the economic factors involved are so tremendous and so complicated that relief cannot be expected without municipal, state and perhaps federal aid—not in any sense as a charity, but as a matter of wise public policy and of justice to those to whom we look for the perpetuation of our family and national life and the prosperity of the people. The sooner we recognize this, the sooner may we expect results. We should get all the facts, formulate a plan of proceedure, count the cost and go to work without further delay.

DIFFICULTIES IN THE WAY OF A SOLUTION

A. Inadequate Birth and Death Registration: The birth registration area includes about 53 per cent of the total population; the death registration area, about 70 per cent. Registration is in the hands of the several states in the respective areas and is therefore dependent upon widely varying conditions of legal enactment and administrative efficiency. The records lack uniformity in nomenclature and classification and differ

widely in completeness and comprehensiveness. What data we profess to have for the nonregistration area are from estimates or guesses based largely on the records of the registration area—some good, some bad, and all deficient in certain important respects. It is evident that from records so incomplete and inaccurate, the preparation of vital statistics of definite value is impossible.

In the countries having the lowest infant and maternal mortality rates, national birth and death registration has been in existence for a long time: Sweden since 1749; France and Norway since 1801; Prussia since 1816; England and Wales since 1838; and New Zealand since 1871. Efficient administrative measures and the education of the people have brought the birth and death statistics in these countries to a high degree of completeness.

As it appears, the position of the United States among the civilized nations of the world, in regard to infant and maternal mortality, is just about what might have been expected from our birth and death registration.

B. The Economic Impossibility of Providing Competent Obstetric Care for What the People are Able or Willing to Pay: As previously pointed out, the problem is very largely an economic one. Because they are unable to pay for anything better, the work among the poor has been left very largely to midwives and incompetent practitioners. Even among people in more comfortable circumstances the choice of an obstetric attendant is all too frequently determined by the size of his fee. So long as obstetric standards are dependent upon the economic status of the individual it will not be possible to raise them.

C. Low Obstetric Standards: The question naturally arises as to what extent doctors are responsible for the present-day standards of obstetric practice in this country. There can be no question but that the great majority of doctors practicing obstetrics to-day received very poor training during their college days. We are reaping today, moreover, the harvest from the planting done by diploma mills and proprietary medical colleges of former days, many of whose graduates are still in the most active years of practice. We can hope for little improvement until the doctors who are being educated to-day supplant these older men.

It is true that great improvement in the teaching of obstetrics in the medical schools and hospitals of the country is indispensable to the solution of the problem; and yet, the teaching, however good, will leave untouched the social, economic and administrative difficulties which are far greater and vastly more complicated in obstetrics than in any other branch of medicine. For example, take surgery. The American College of Surgery is doing a wonderful piece of constructive work in standardizing surgery—in saying who shall and who shall not practice surgery in the future. Why not standardize obstetrics in the same way? Obstetrics is a branch of surgery; its successful practice is dependent upon surgical principles and surgical technique. The answer is plain. The obstetricians of the country are the family doctors and the midwives, who know nothing about surgery.

Moreover, all surgery is done by physicians, usually under favorable hospital surroundings. The people understand that surgery cannot be done safely outside of hospitals; adequate hospital facilities have thus been provided, the work is under good control, the results are satisfying and inspiring. The poor receive just as good care as the rich and adequate compensation is generally assured. How different with obstetrics: less than 5 per cent of confinements occur in hospitals; only two classes of patients receive standard care—the poor in hospital wards and dispensaries and the well-to-do, both usually in the hands of specialists, and probably not over 10 per cent of the cases.

Every teacher in obstetrics knows that when the young doctor receives his diploma he is no more fit to practice obstetrics than he is fit to practice surgery or opthalmology. The people know it in respect to surgery and opthalmology and will not employ him; the doctor himself knows it and takes special courses and serves long apprenticeships before he will accept the responsibility. But in obstetrics, without special training, the young doctor will accept anything that comes along from the day he hangs out his sign. And, why not? It is expected of him. The midwives are doing it without training; the doctors about him are doing it and with perhaps less training than he; and then too, obstetrics opens the way to family practice which, after all, is what he wants.

Obstetric standards are low very largely, also, because the people are not convinced that special training and skill are needed. Obstetrics comes from a Latin word meaning "to stand before" or as a sneering colleague once said, "to stand around." From the days of ancient Egypt and Greece old women have been standing around at confinements; and now, much as then; and all that many doctors are able to do is to stand around; in fact, anyone can stand around, anyone can do the job. Such a thing as the "science and art of obstetrics" does not exist for most women; over them the mediaeval cloak of ignorance, superstition and fatalism still hangs, shutting out the light of the present day. In this lowly and despised position, the hand-maiden of obstetrics finds herself among her more favored sisters of medicine.

D. The Opposition of the Medical Profession: Perhaps the most formidable opposition to fundamental changes in the practice of midwifery as it exists to-day will be found in the medical profession.

At the meeting of the American Gynecological Society in June, 1921, Dr. Robert L. Dickinson of Brooklyn made the following statement: "Medicine is proverbially myopic. We refuse to see what the social workers see; therefore the social worker has got busy and proposed a remedy. What do we do? We try to thwart it. The Sheppard-Towner Bill is not what we prefer or favor; therefore instead of taking half a loaf, we refuse bread. We refuse appropriations if the money does not go where it belongs. If it is not done by the state, it is helped by the nation, therefore it is bad legislation and we will refuse it. . . . We must welcome these statistics on prenatal care, however bad they are in form. . . . For nearly twenty years I have tried to do what little I could to leaven the mass of the obstetric work of the general practitioner, to raise that level. Gentlemen, whatever progress we have made in our maternities, we have failed to raise that level. Let us then in God's name welcome any outside help, however mistaken, for social health insurance and all the rest are inevitable; we cannot stop it."

I come from Pittsburgh which had in 1920 the highest infant mortality rate of any "of the large American cities for which reliable records are available." Pittsburgh also had in 1920 a maternal mortality rate of 9.6 per 1,000 confinements (149 in 15,508)—a rate of 9 per cent higher than the rate (8.8) for the entire birth registration area in 1918, and 109 per cent higher than New York City's rate (4.6) for the same period. To me at least these rates are significant.

In 1909 I did the first organized prenatal work that had been done in Pittsburgh. In 1912 the Pittsburgh Maternity Dispensary began work under my direction as Professor of Obstetrics in the University of Pittsburgh and Medical Director of the Magee Hospital. In six years over $80,000 was spent in support of the work, every dollar of which was contributed by my patients and friends. During this time 3,384 confinement cases were cared for in the tenements by the dispensary. Over 56,000 visits were

made to these patients by the dispensary nurses, social workers, and doctors—all full-time workers on salaries. Fifty-eight per cent of the women were foreign born and 16 per cent were negroes. There were 6 maternal deaths—a rate of 1.7 per 1,000 confinements; and the fetal mortality was 6.2 per cent for stillborn and babies dying during the first two weeks following birth.

I was also responsible for the plans, furnishing and equipment, and organization of the work of the Magee Hospital which was regarded as the most modern woman's clinic in the country. The hospital and dispensary combined to form a public welfare and teaching unit, the equal of anything to be found anywhere. But the work done by these two institutions was bitterly opposed by the medical profession of Pittsburgh, with the result that the Allegheny County Medical Society preferred "charges of unprofessional conduct" against me—as their directing head—as follows:

In connection with the hospital—"for acquiescing in a policy which is detrimental to the public and the profession" —that is, the policy of a closed hospital with 21 private rooms.

In connection with the dispensary—"for taking patients which are able to pay a private physician; for taking patients which had already engaged a physician; and for soliciting patients."

I was declared guilty of these charges and suspended from the Society as the sentence read—"for one year or until the things complained of are corrected." Three years later, in October, 1918, as a war measure I was separated from my work, the hospital being commandeered for government service. Thus in a day the work of fifteen years was swept away.

Please do not miss the point of this recital. What happened to me is not in the least important. But it is important to remember that these charges were all based upon purely financial considerations, the lessening of doctors' incomes as the result of free hospital and dispensary care given to patients unable to pay for it.

Pittsburgh is perhaps not different from other places; it appears, in fact, that the opposition of the profession is everywhere much the same. The rights of the patient to good care, her inability to pay, even life and death become secondary considerations. Thus the whole matter assumes the aspect of a commercial proposition, with the patients the stock in trade and the doctors determined to keep the business. On the other hand, the people are coming to understand that there are many thousands of unnecessary deaths each year in the practice of midwifery as the result of ignorance and neglect; the Sheppard-Towner Bill is the "handwriting on the wall"—the proclamation that the people are about to demand that something be done about it. What shall be done under the circumstances, that is, with these two opposing forces in conflict, is a part of the question which I am expected to answer.

THE REMEDY

A. Uniform Birth and Death Registration for the Entire Country; Vital Statistics Sufficiently Comprehensive to Give All the Facts Pertaining to the Mortality and Morbidity of Maternity and Infancy: As stated by Howard, "Vital statistics holds the same relation to advance in public-health knowledge and administration that pathological anatomy bears to the advance of fundamental knowledge in clinical medicine and surgery."

Dependable vital statistics gives the only findings upon which an intelligent statement of the problem under consideration can be made; furnishes the only reliable data for the institution of corrective measures; and provides the only means of judging results obtained. Vital statistics, moreover, gives a survey of the field and picks out the black spots therein, while registration records fix the responsibility in individual cases and thus point the way for correction or improvement. Without some such system of

effective checks upon the work of obstetric attendants followed by aggressive remedial procedure, marked improvement in the practice of midwifery may not be expected and the solution of our problem is impossible.

We talk long and loud about supervising the midwife but not a word about supervising the doctor. In standardizing surgery, the hospital records are used as checks upon the individual surgeon and the method employed for supervising his work. As 95 per cent of the obstetrics is done in the homes, the birth and death records and vital statistics compiled therefrom are the available checks upon the individual obstetric practitioner and may be used effectively in supervising his work.

To be of any great value in the solution of our problem, registration must be reasonably complete and must be uniform throughout the country. In my opinion this will never be accomplished except through national registration—financed and directed by the Federal Government and under Civil Service.

The first state in the Union to adopt registration, was Connecticut—73 years ago; the second was Rhode Island—51 years ago. If left to the states, many years will pass before registration covers the country and when it comes, it will be much as now.

No attempt should be made at this time, however, to secure federal registration. The first step should be the establishment of a federal department of public welfare or public health with its executive head a member of the President's Cabinet. In the law creating this new department, provision should be made for a bureau of birth and death registration and vital statistics, through which all the other bureaus having to do with health matters can best be coördinated—as vital statistics is the one common meeting ground upon which they can come together. At present there are 33 different bureaus engaged in some sort of health and welfare work scattered through the various departments of the government. They should be brought together under one roof, closely coördinated and operated under a common policy with a single directing head.

B. The Extension of the Work of the Children's Bureau as Contemplated in the Sheppard-Towner Bill: I am in thorough accord with the provisions of this Bill. Its enactment into a law* will mark the beginnings of better things for American mothers and babies and will be an appropriate endorsement of the splendid work of the Children's Bureau during the nine years of its existence.

There are two suggestions which I should like to make:

1. That the million dollars to be apportioned among the several states should be contingent upon acceptable birth and death registration within the states. The appropriation is relatively so small that at best but a small percentage of the work can be cared for during any one year. It will be better, therefore, to limit the work to the states having good statistics in order that something definite may be accomplished. If this plan were followed, I believe that the ineligible states would soon fall in line by adopting registration, largely out of state pride, partly to get the money. In the meantime the delinquent states would have the $10,000 each year appropriated by the Federal Government, for purposes of propaganda, which undoubtedly would hasten the day of registration and of additional federal aid.

2. That in planning for the work within the several states, an effort should be made to concentrate upon a limited number of cities and rural districts, in order that the whole problem may be worked out for each place where it is undertaken. The places chosen should be selected because of certain typical social, economic and industrial conditions more

*Since this address was delivered, the Sheppard-Towner Bill has become a law.

or less representative of the states in which they are located, keeping in mind always the advisability of cleaning up the worst spots first.

C. Specific Administrative Measures: Two classes of patients constitute the problem of this paper: Class I—the so-called "poor" who are able either to pay nothing or but a part of the cost of caring for them, and Class II—the women of the great middle class who are unwilling to accept free care and too proud to avail themselves of the public wards of hospitals, and yet are financially unable to employ the trained obstetrician and to pay for the things which as a matter of course go with him, and who consequently fall to the lot of the underpaid and usually incompetent practitioner.

It is evident that these two classes must be provided for upon entirely different bases.

Class I: The vast majority of these women will remain at home for confinement, but an increasing number will go to hospitals.

Hospitals: For the care of those women who cannot for one reason or another remain at home, hospitals are of course indispensable; and for the training of doctors, nurses and midwives as it should be done, the crying need of the day is for modern maternity hospitals, specially constructed, suitably equipped, properly conducted, and liberally endowed. Such hospitals in sufficient numbers is the solution for the hospital care of patients of this class, which as it happens furnish also the obstetric teaching material. In medical teaching centers, therefore, these hospitals should be under the control of medical schools.

In any scheme to provide home care for patients of this class, trained workers in sufficient numbers must be anticipated to meet the demands of the growing work. With the growth of the home service, not only will increased hospital facilities be necessary to supply the trained workers needed, but increased hospital service will also become necessary to care for the increasing number of patients discovered to be unsuited for home care. Thus the hospital and home services are interdependent and must be developed together, and together they cover the entire field of obstetric service to the patients of Class I.

Maternity Centers for the Home Service: I wish to say very positively that I do not believe that the midwife is the solution of the problem in the home service to the poor. It is true that the foreign-born women prefer midwives from custom, but it has been my experience that if you have anything to offer which is really better than the midwife and costs no more, even the foreign-born women are quick to avail themselves of it. It will not get us anywhere to say that midwives do just as good work as the average doctor, which may be true. It should not be a question of the lesser of two evils. Neither is fit. We want something better; we want well trained doctors to attend women in confinement. The only question is as to how they may be provided. The answer is, "By paying them a living wage." And this can be done, not as heretofore, by placing the entire burden upon the doctor; and certainly not by paying specialists' prices out of the public treasury to each doctor for caring for a few cases. The doctor must be enabled to get his money from small fees received from a much larger number of patients cared for under time-saving and strength-conserving conditions; he must do his work at the minimum expense to himself, and he must not be asked to do any work for which he is not paid the stipulated fee. This means that the public must provide the administrative machinery and the physical equipment necessary to the successful prosecution of the work from the obstetric standpoint; and that the doctors

must be relieved of all work that can be done by others—public-health nurses, social workers, and midwives.

The social worker should be charged with the responsibility of deciding upon the eligibility of patients for admission to Class I and of fixing the charge, if any, in each case. As far as possible, her decisions should be based upon instructions and schedules provided by a governing board. This procedure would eliminate controversy and remove doubt as to whether or not certain individuals are entitled to the service.

The nurses should be trained to do all the antepartum and postpartum work, from both the doctors' and nurses' standpoints, with the doctors always available as consultants when things go wrong; and the midwives should be trained to do the work of the so called "practical nurses," acting as assistants to the regular nurses and under their immediate direction and supervision, and to act as assistant-attendants upon women in labor —conducting the labor during the waiting period or until the doctor arrives, and assisting him during the delivery.

In this plan the work of the doctors would be limited to the delivery of patients, to consultations with the nurses, and to the making of complete physical and obstetrical examinations on patients at the time of their admission to the service. The doctors should be paid a stipulated fee for each case on the basis of all the confinements cared for during a given period. Under this arrangement the doctors would have to work together in a coöperative association with an equitable distribution of the work and earnings.

Class II: The best solution of the problem for this class of patients is the maternity hospital with a sufficient number of moderate-priced private rooms, built and equipped by municipal appropriations and private benefactions, operated on a cost basis, and the patients cared for by private doctors working together in private coöperative associations as described so as to be able to charge fees commensurate with the patients' circumstances.

I fully realize that the weak point in the plan proposed is that the doctors would in all probability oppose it, as they are opposed to any plan which includes municipal or state aid looking toward the solution of the problem on a public-health or public-welfare basis.

In the period of readjustment in medicine which is opening before us, every effort should be made to avoid anything which tends to weaken the morale of the profession and to destroy individual initiative and individual freedom. The estrangement of the medical profession in the practice of midwifery will react upon the whole medical fabric with great injury to the public good. Every effort should, therefore, be made to secure the coöperation of the profession, which I am sure will be impossible if large numbers of midwives are trained to supplant physicians in the practice of midwifery.

On the other hand the doctors must make up their minds to a compromise in the matter. It is still in their hands to effect a reorganization in their own interests, if they will organize not to keep up prices but to do the work which must be done at prices which the people can pay. The great fear is, however, that they will not listen to reason and that when the people come to know all the facts of the midwifery problem, an attempt will be made to solve it without their coöperation.

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