STATEMENT OF DR. FRED L. ADAIR, REPRESENTING THE ADVISORY COMMITTEE ON CHILD WELFARE

Dr. ADAIR. My name is Dr. Fred L. Adair. I am professor and chairman of the department of obstetrics and gynecology of the University of Chicago, 5848 Drexel Avenue, Chicago, Ill.

I wish to make a few points without much elaboration. One of the points with reference to maternity care is whether there is a need for improved maternity care. The answer in one regard is that there is a lack of generalized maternity care throughout the country. This applies particularly perhaps to smaller communities and to rural communities. In other words, there is no complete program of maternity care, including the period of pregnancy, labor, and the post-partum period. Probably in individual instances in communities women are given the best maternity care in this country of any country in the world, but in contra-distinction to that we have in other instances probably the poorest care of any country in the world. This is shown by our mortality, which is relatively low in comparison with some countries, and also by the very great variability within our own country. In some communities it is twice as high as it is in others, which is difficult to explain.

Mortality is only one index of the results of maternity care. We also have to consider morbidity, or sickness and disability which results from childbirth, which often leads to prolonged disability and incapacity.

How is this to be accomplished? We have physicians and individuals in various communities who realize their individual responsibility to various patients, and so forth. I think we must develop an idea of community responsibility in the minds of doctors and others who have to do with the care of maternity cases. This involves education of the laity so that they will cooperate. This is shown in an analysis of mortality statistics. Many of the cases who die never receive, largely due to their own lack of knowledge or carelessness, the proper sort of care which they should have received. It requires further medical education because the training in maternity care in medical institutions in the past has not been what it should have been. It has improved a great deal at present, but we still have practicing many men who never have received adequate maternity education and training. It must be necessary and it will be helpful to reeducate and supplement their previous education.

The same fact is true relative to nurses in regard to maternity training. Some nurses receive excellent maternity training in the nursing schools of the country. In others it is entirely inadequate.

The sine qua non for the carrying out of this program is the cooperation of the doctors. The doctors are the only ones who can render competent and adequate maternity care, and their cooperation must be secured. My suggestions as to the methods of securing this cooperation with the medical profession are, first, that medical leadership be provided for; second, that no interference with the economic status or the economic security of the physician be brought about in developing such a program; and lastly, the practice of medicine being a profession, that the ideals and ethics of the medical profession should not be compromised.

In reference to a question which was asked a previous speaker relative to the causes of maternal deaths, I would like to say that three-fourths of the maternity deaths are due to controllable causes; not that they would be absolutely preventable, but they are relatively preventable. The main causes in producing maternal deaths are infection, so-called "toxemia", or a toxic state arising during pregnancy, and hemorrhage. Approximately 40 percent of the deaths are due to infection. Infected abortions contribute considerably to this. The toxic states contribute perhaps to 20 or 25 percent of the deaths, and hemorrhages 10 or 12 percent.

Mr. REED. Doctor, would you give us some idea of the number of children that are made blind as a result of neglect during childbirth?

Dr. ADAIR. If preventive measures are carried out at the time of birth it is practically none.

Mr. REED. It is caused from neglect?

Dr. ADAIR. In most States or communities where those measures are not carried out, it is a very important factor, that is, from the standpoint of both venereal diseases. But in States where it has been carried out effectively, it is not much of a factor any more.

Mr. DISNEY. Doctor, has infant mortality been on the increase or decrease in modern times?

Dr. ADAIR. In considering infant mortality we have to consider both the still births, that is, the dead-born infants, and the deaths during the whole period of infancy. The infant mortality subsequent to live birth has decreased during the first year or the first 2 years of life very materially.

Mr. DISNEY. To what extent?

Dr. ADAIR. The decrease during the early weeks of life has not been so markedly reduced, though the last few years have shown some reduction. The number of still births has practically not decreased at all.

Mr. DINGELL. Doctor, you mentioned the increase in the death rate in maternity cases is influenced to a great extent by abortions.

Dr. ADAIR. Yes, sir.

Mr. DINGELL. Are there any available figures to indicate what percentage are due to so-called "therapeutic abortions" and which might be termed criminal?

Dr. ADAIR. Yes. Statistics show that from one-fifth to one-fourth of all maternal deaths follow abortion. Infection causes about three-fourths of these deaths from abortion of all maternal deaths from infection about one-half result from infected abortions. The mortality in properly performed therapeutic abortions is very, very slight, whereas in the so-called "criminal" abortions it is relatively high, mostly from infections.

Mr. DISNEY. Longevity in the United States has greatly increased in the last 50 years, has it not?

Dr. ADAIR. Yes. I think probably one main factor—there are many factors, of course—is the decreased infant mortality

Mr. DISNEY. To what extent has longevity increased?

Dr. ADAIR. You mean the total longevity?

Mr. DISNEY. In the last 50 years.

Dr. ADAIR. I do not know that I can give you any absolute figures——

Mr. DISNEY. About 15 years.

Dr. ADAIR. But I think the decrease in the infant mortality has been a factor in the increase of average longevity.

The CHAIRMAN. We thank you, Doctor, for your appearance and the information you have given the committee.

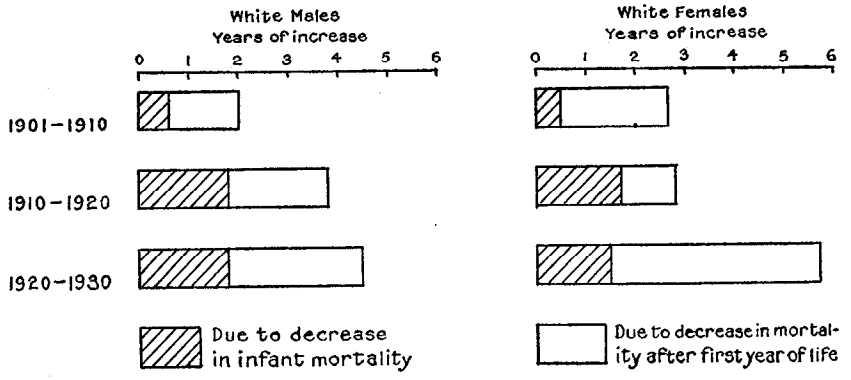
(Dr. Adair submitted the following for the record:)

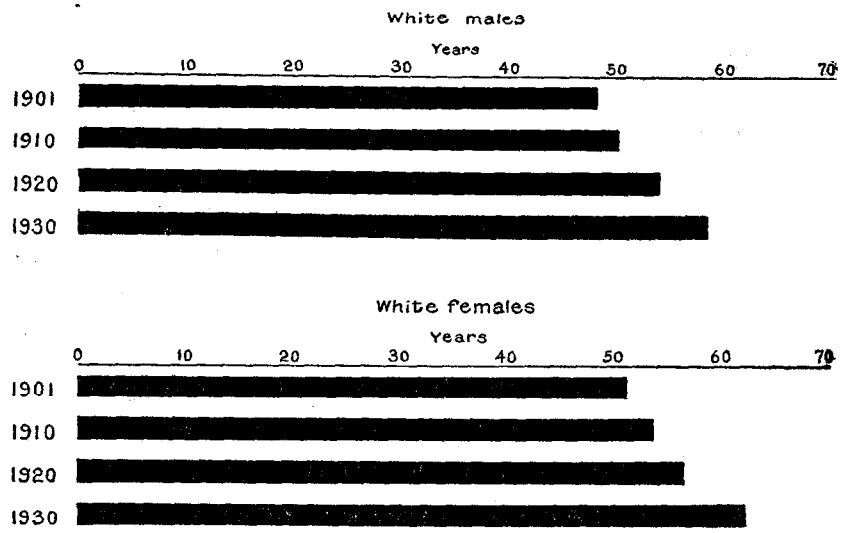
The best figures for showing increase in the expectation of life are the life tables of the United States Bureau of Census for the original death-registration States, which include roughly one-fourth of the population of the United States. These tables show that expectation of life at birth was for white males 48.23 years in 1901 as compared with 58.57 years in 1930, and for white females 51.08 years in 1901 as compared with 62.14 years in 1930, as is shown in the accompanying chart. In other words, there was an increase of 10.34 years in the expectation of life at birth for white males during this period and an increase of 11.06 years in the expectation of life for white females. These increases in the expectation of life are due to improvement in conditions affecting mortality at all ages. During this period 1901–30 improvement in conditions affecting children under 1 year of age added 4.32 years to the expectation of life at birth for white males and 3.9 years to the expectation for white females. In other words, about 42 percent of the increase in expectation for white males from 1901 to 1930 and 35 percent of the increase for white females is due to lessened mortality in the first year of life.

The accompanying graph shows increase in the expectation of life in each decade due to conditions affecting improvement in mortality at all ages and in the first year of life. The downward trend in infant mortality during these decades is shown by the following rates:

Infant mortality rates per 1,000 population under 1 year in the original registration States

	White males	White females
1901	133.45	110.61
1910	123.26	102.26
1920	92.43	73.61
1930	61.78	49.17





STATEMENT OF DR. CLIFFORD G. GRULEE, REPRESENTING THE ADVISORY COMMITTEE ON CHILD WELFARE

Dr. GRULEE. My name is Clifford G. Grulee, 1410 Asbury Avenue, Evanston, Ill. I am professor and head of the department of pediatrics at Rush Medical College at Chicago, and secretary of the American Academy of Pediatrics.

First I would like to present to you the letters of several of my colleagues scattered all over the country in support of this bill. Shall I read the names?

The CHAIRMAN. Without objection, you may.

Dr. GRULEE. Dr. E. J. McCollum, of Johns Hopkins; Dr. A. Graeme Mitchell, of Cincinnati; Dr. Howard Childs Carpenter, of Philadelphia; Dr. Joseph Stockes, Jr., of Philadelphia; Dr. Warren Sisson, of Boston; Dr. Oscar M. Schloss, of New York; Dr. Borden S. Veeder. of St. Louis; Dr. Thomas B. Cooley of Detroit; Dr. Harold C. Stuart of Boston; Dr. Richard M. Smith, of Boston; Dr. Kenneth D. Blackfan, head of the department of pediatrics of Harvard; Dr. William Palmer Lucas, of San Francisco; Dr. Edward Clay Mitchell, of Memphis; Dr. Lawrence T. Royster, of the Univessity of Virginia; Dr. Samuel McClintock Hamill, who was chairman of the medical committee of the White House Conference.