

U. S. DEPARTMENT OF LABOR

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CHILDREN'S BUREAU

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STANDARDS OF PRENATAL CARE

AN OUTLINE FOR THE USE
OF PHYSICIANS



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FOREWORD

At a meeting of the directors of the State bureaus of child hygiene held at the Children's Bureau in Washington in October, 1924, it was suggested that a committee from various parts of the country be appointed to draw up standards of prenatal care for the use of physicians at clinics and also in private work. The Children's Bureau accepted that suggestion and requested the writer to form such a committee.

With the help of the chief of the Children's Bureau the following committee was appointed, and the accompanying pamphlet is the result of its work: Dr. Fred L. Adair, associate professor of obstetrics and gynecology at the University of Minnesota Medical School; Dr. Rudolph W. Holmes, associate professor of obstetrics and gynecology at the Rush Medical College, University of Chicago; Dr. Ralph W. Lobenstine, chairman of the medical advisory board of the Maternity Center Association of the City of New York; Dr. Frank W. Lynch, professor of obstetrics and gynecology, University of California Medical School; Dr. Florence L. McKay, director of the division of maternity, infancy, and child hygiene, Department of Health of the State of New York; Dr. James R. McCord, professor of obstetrics and clinical gynecology, School of Medicine, Emory University, Atlanta, Ga.; Dr. C. Jeff Miller, professor of obstetrics and clinical gynecology, Tulane University of Louisiana School of Medicine; Dr. George Clark Mosher, chairman of committee on maternal welfare, American Association of Obstetricians and Gynecologists; Dr. Otto H. Schwarz, associate professor of obstetrics, Washington University Medical School, St. Louis, Mo.; Dr. Annie S. Veech, director of the bureau of maternal and child health, State Board of Health of Kentucky; and the writer.

An outline of possible standards of prenatal care was sent to each member of this committee, and after much correspondence a meeting was held in Washington on May 2, 1925, at which the following members, in addition to the writer, were present: Doctor Adair, Doctor Schwarz, Doctor McKay, Doctor Mosher, Dr. Alice Pickett, of the University of Louisville, Medical School (designated by Doctor Veech, who was unable to be present, to act in her place), and Dr. Florence E. Kraker, acting director of the maternity and infant-hygiene division of the Children's Bureau.

It was obvious at the beginning of the correspondence and in the committee meeting that only by intelligent compromise could such a group of physicians agree on what was essential for inclusion in the standards of prenatal care. It was soon seen that if each should insist that everything he thought essential be put in, the bulk of the resulting document would make it useless to the medical profession. Therefore in a spirit of compromise each member of the committee

made concessions on certain details he would have liked to see included in the standards, and the result is this concise, simple, workable outline.

After the committee meeting in Washington the final draft was approved by each member, and the standards in their present form represent therefore a unanimous report of the committee.

The committee appreciates that no group of physicians would agree without qualification on any set of standards such as has been attempted, but it does feel that the bulletin covers the essential points in prenatal care which all physicians should be called upon to give their patients.

ROBERT L. DE NORMANDIE, M. D.,
Chairman of the Committee.

BOSTON, MASS.

STANDARDS OF PRENATAL CARE¹

Prenatal care is that part of maternal care which has as its object the complete supervision of the pregnant woman in order to preserve the happiness, health, and life of the mother and child. Therefore all pregnant women should be under medical supervision during their entire pregnancy, for it is only by careful routine prenatal care that pregnancy and labor can be made safer.

I. The physician at the first visit should obtain the following data and record the facts:

A. Patient's past history—

1. Diseases. Question particularly as to the following:

(a) Tuberculosis or exposure to tuberculosis.

(b) Scarlet fever.

(c) Tonsilitis.

(d) Rheumatism.

(e) Diphtheria.

2. Surgical conditions and accidents, especially abdominal and pelvic operations.

3. Menstrual history—cycle, amount of flow, duration, and pain.

B. Character of previous pregnancies and labors. Secure the following data of previous pregnancies in chronological order:

1. Date of termination.

2. Period of gestation.

3. Complications during pregnancy.

4. Labor.

Onset—spontaneous or induced.

Character.

Duration.

Termination of labor.

Spontaneous or artificial.

If artificial, what method.

Other complications.

5. Puerperium.

Infection.

Hemorrhage.

Operations following.

6. The newborn.

Alive or dead at birth.

If dead, macerated?

Premature or term.

Breast fed—yes or no. Duration.

Baby alive now? If dead, give cause of death.

¹ No attempt has been made in this pamphlet to direct actual treatment, particularly for such conditions as nausea or vomiting, preeclamptic toxemia, and the treatment of syphilis during pregnancy. The physician using this outline is referred to standard works in obstetrics and other branches which deal adequately with these phases of the work.

C. Present pregnancy:

1. Date of last menstruation and character thereof.
2. Nausea and vomiting and quickening.
3. Estimation of date of delivery.

II. Then proceed to—

A. Physical examination.

1. Taking and recording of the systolic and diastolic blood pressure, temperature (preferably p. m.), pulse, and weight.
2. Skin, nutrition, head, mouth, neck, chest, heart, lungs, breasts, extremities.
3. Abdominal examination, palpation, auscultation, mensuration.
4. Vaginal examination. No vaginal examination during the last month of normal gestation without strict aseptic precautions. Rectal examination should be substituted.
 - (a) The necessity of a vaginal or rectal examination is insisted upon—
 - (1) To determine the existence of a pregnancy.
 - (2) To determine the position of the uterus.
 - (3) To discover any pelvic tumor.
 - (4) To determine the presence of venereal disease, and if suspected to take smears.
 - (5) Speculum examination of the cervix and vagina is advised in early pregnancy if indicated.
 - (b) In presence of vaginal bleeding at any period of gestation only rectal or aseptic vaginal examination should be made.
5. Pelvic measurements.
 - (a) Intercristal.
 - (b) Interspinous.
 - (c) External conjugate.
 - (d) Diagonal conjugate.
 - (e) Transverse diameter of the outlet.
 - (f) Palpation of pelvic contours, promontory, sacrum, coccyx, ischial spines, arch, tuberosities.
6. Taking of blood for Wassermann reaction.
7. Urinalysis.

Specific gravity. Albumin. Sugar.

A microscopic examination of the sediment is advisable as a matter of routine, and it is a necessity if albumin is present. If there is any evidence of trouble, a 24-hour specimen should be secured.

III. If pregnancy is determined, then give minute instructions to the patient in the hygiene of pregnancy.

NOTE.—Refer to publications of the United States Children's Bureau, Washington, D. C.—Prenatal Care, Publication No. 4, and What Builds Babies, Folder No. 4—and to publications of State department of health.

- A. Diet.
- B. Exercise, rest, sleep, and recreation.
- C. Clothing, including shoes.
- D. Baths and care of the skin.
- E. Care of the bowels.
- F. Care of the kidneys.
- G. Care of the teeth.
- H. Care of the breasts.
- I. Intercourse during pregnancy.
- J. Maternal impressions.
- K. Hygiene of the home and preparation for home delivery.
- L. Mental hygiene.

Patient should be examined by a physician at least once a month during the first six months; then every two weeks or oftener as indicated, preferably every week in the last four weeks. A properly qualified nurse working in conjunction with a physician may assist in the observation of the patient. At each visit to the physician the patient's general condition must be investigated, blood pressure taken and recorded, urinalysis done, pulse and temperature recorded, and the weight of the patient taken if possible.

External pelvimetry is only suggestive. It alone does not determine whether any disproportion is present. Abdominal examination should be made at each visit and the height of the fundus determined at this examination. Abdominal palpation in the eighth and ninth months will show whether or not there is any obvious disproportion between the head and the pelvis. Malpositions can be determined and may be corrected. Further information as regards descent and fixation can be obtained by rectal examination.

In a primigravida, if the presenting part two weeks before the estimated date of delivery is not well in the pelvis, the physician in charge should determine, so far as is possible, whether any disproportion between the pelvis and the baby exists. If a disproportion is diagnosed in any case special care should be taken to avoid vaginal examinations immediately prior to or after the onset of labor. This precaution is wise because of the danger of serious infection should operative procedures later become necessary.

Every patient requires careful individual study. If the prospective labor offers a probable chance of being a difficult one, the patient should be sent to a well-equipped hospital for delivery.

Pregnancy is a physiological condition, but there is no condition which so quickly may become pathological. It is therefore necessary to instruct each patient at her first visit to report at once to the physician anything that may affect her well-being, especially the following symptoms:

1. Obstinate constipation.
2. Shortness of breath.
3. Acute illnesses, especially colds, sore throat, and persistent cough.
4. Persistent or recurring headache.
5. Recurring nausea or vomiting.
6. Visual disturbances.
7. Dizziness.
8. Pain in the epigastrium.
9. Edema, especially of face, hands, and ankles.
10. Changes in the urine or in the type of micturition.
11. Severe pain in the lower abdomen.
12. Vaginal bleeding, even the slightest.

In case of vaginal bleeding or low abdominal pain the patient must be instructed to go to bed at once and to send for her physician. When bleeding from the vagina occurs its source must be determined by examination. When hemorrhage appears imminent the patient, if possible, should be removed to a hospital, but if vaginal examination is necessary it must be done under aseptic precautions. Where a hospital is not available, means must be at hand to control the possible severe bleeding that may arise.

If the patient develops a toxemia in the course of her pregnancy it is only by careful medical supervision and treatment that an eclamptic condition can be prevented. Eclamptic convulsions are in the majority of cases preventable, but only by constant vigilance combined with cooperation between the patient and the physician can the disastrous results which occur throughout the country be diminished.

If the patient is to be delivered by a licensed midwife, she should have the advantage of the same prenatal care to which all prospective mothers are entitled. If there is doubt about the patient's having a normal delivery she should be transferred to a doctor or to a hospital.

Only by careful study of each case is it possible to determine whether the patient should be allowed to stay at home or be sent to a hospital. By this individual study the number of vaginal examinations during labor may be cut to the minimum and the terrible toll of death from sepsis be much lowered.

It is only by the early and repeated examination of the prospective mother that the premature termination of pregnancies, the stillbirths, and many diseases and deaths of the newborn can be reduced. By the same methods the mothers can be spared much distress and disease, and many lives can be saved which would otherwise be lost from toxemia, accidents of pregnancy and labor, and infection.

The accompanying form is suggested for use by the physician in his own practice as well as at prenatal clinics.

PREGNANCY RECORD ²

Date	Estimated date of confinement	
Name	Age	
Address	Gravida	Living children

A. Past history

1. Diseases

2. Operations

3. Menstrual history

B. Previous pregnancies and labors

C. Present pregnancy

1. Date of last menstruation and character thereof

2. Nausea and vomiting

Quickening

3. Estimation of date of delivery

² These forms may be obtained from the Superintendent of Documents, Government Printing Office, Washington, D. C., at \$5 per 1,000.
U. S. Department of Labor, Children's Bureau. C. B. 107.

