pregnancy has developed sufficiently far, the fœtal heart is examined and the pelvis is carefully measured. The patient is given careful directions as to the hygiene of pregnancy, and is told to return in four weeks or sooner if any untoward symptoms arise. The name is then given to the nurse who makes the follow-up visits. The out-patients are visited in their homes at regular intervals by the nurses of the Instructive District Nursing Association. Many of the patients that are to be confined in the hospital are visited, however, by the nurse who is on duty in the pregnancy clinic, and this is the ideal arrangement for the best kind of service.

Should, however, the patient give a history of previous difficult labour, or should she be a primipara, she is referred to the front room and a careful vaginal examination is added to the examination previously described. Should the pelvis show marked contraction and the patient be nearly at term, she is sent to the hospital for consultation. Should a patient show albumin in the urine or a high blood-pressure, if the symptoms are acute, she is sent to the hospital for treatment. If the symptoms are mild, she is told to return to the clinic for examination in three days, in five days, or at the end of a week, depending on the severity of the symptoms. When the patient returns for her subsequent visits her urine is examined and her blood-pressure taken.

To show the work that we are doing, I have carefully reviewed the records of 1,000 cases, beginning with the first case that made application after the present system was fully established.

Of this series 609 cases were delivered in the patients' own homes by student externes and the out-patient staff of the Boston Lying-in Hospital. Two hundred and thirty were delivered inside that hospital by the house staff.

Turning to the 609 cases delivered in the out-patient department, 608 were married and one only was single; 157 were pregnant for the first time, while 452 had had one or more previous pregnancies; 545 had normal deliveries. The average length of time that the mothers were under the care of the out-patient department after delivery was twelve to seventeen days; 600 mothers were discharged well.

The infants were under the care of the out-patient department for an average length of time of twelve to nineteen days. Five hundred and seventy-six were discharged well. There were fourteen still-births. Six died from other conditions. This would give a rate per 1,000 births of 22.9 stillbirths, which compares favourably with Boston's rate of 39.8 and Borough of Manhattan's 48.6.

As this paper is limited in length, I will not go fully into the statistics of the patients delivered in the hospital, but I feel obliged to state that this rate of stillbirths is not so satisfactory. The total for all these 839 cases delivered in the hospital and the out-patient department combined is 35.3 per 1,000 births. Three patients seen in pregnancy clinic subsequently developed eclampsia in the hospital, and one of these died. None of these three showed any symptoms of toxæmia while under observation in the pregnancy clinic.

On the other hand, the seventeen cases showing symptoms of toxæmia and referred to the hospital escaped without serious trouble. It is only fair to state that of these 230 cases followed by the pregnancy clinic, for various reasons only sixty-five were visited by the pregnancy nurse.

On the previous pages I have described in detail the workings of an actual institution and the results obtained. Now I want briefly to sketch a more nearly perfect system. In this ideal pregnancy clinic all patients should apply without reference to the subsequent confinement, being guided as far as they are willing by the physician in charge. The nurse who receives the patient and assists the physician in making the examination should be in each and every case the nurse who will make the follow-up visits. This nurse should be trained to take the blood-pressure and make the nitric acid test for albumin, and carry with her on her visits to the patient's home the necessary apparatus for taking these observations. From the date of application the patient should be visited by the nurse or report to the clinic at least every two weeks. Patients failing to report at the clinic should be traced by the nurse. All patients when applying to the pregnancy clinic should be given a complete physical examination. In the clinic the urine examination should include an examination of the sediment in every specimen showing albumin by the heat test. Such an ideal pregnancy clinic must be associated with a hospital providing beds and adequate obstetrical care for the graver complications of pregnancy and for operative obstetrics. It should also be associated with an out-patient service providing care for patients in their own home. What would be the estimated cost of such an institution, exclusive of the care of confinement and puerperium or the services of the physician during pregnancy? We have found the rental of the necessary quarters to house such an institution would be $300 per year; the initial expense of fittings and office furniture $100. This clinic would require three nurses to make the necessary visits. If living in the hospital provided, such nurses could be obtained in Boston for $500 a year. Car fares for one nurse in 1912 amounted to $40.10; gas for heating water and lighting in winter cost $38.80; the services of a maid to clean the rooms cost in 1912 $42; stationery, drugs, and instruments cost $120.75. So the total cost of such an institution caring for 2,000 cases annually would be $2,321.55 for the first year, and $2,221.55 for subsequent years, as the wear and tear of office fittings is slight. Thus with each patient paying $1.16 the thing could be accomplished. It would seem that for a practically nominal cost to the individual the hygiene of pregnancy could be supervised intelligently in any community offering over 500 pregnancies for observation annually.

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