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Midwifery in the United States

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Midwife—American midwife: I wonder what picture that brings to your mind? Do you visualize an old granny you once knew who helped when babies came? Do you think of the old superstitious colored women found in some of our Southern States? Do you think of a graduate of the Bellevue School for Midwives? Do you think of an efficient well-trained European midwife? Do you see a nurse-midwife on horseback, or, do you see one of the nurse-midwives recently trained at the Maternity Center Association? Whatever images you have will color your interest and your emotional attitude toward the discussion of this topic.

The untrained group that some of you have visualized is definitely not part of any ideal program of adequate Maternal Care, nor are they midwives in any true sense of the word. Their only right to the title is that they themselves decided that they were midwives, and, in the course of time, the State licensed them as such.

Those of us who know the homes in different parts of our country know that there are large areas where untrained midwives have worked, are working, and will continue to work until they are replaced by doctors and nurses. We also know that the work of the untrained midwife can often be improved by patient, skilful teaching as has been practically demonstrated in different states; for example in Maryland. There a nurse-midwife taught the untrained midwives and followed up her instruction by working in the homes with these midwives to see whether learning had or had not actually taken place. It is obvious that if a midwife is incapable of learning she should not be licensed; neither should she be licensed if she does not function within the legal confines of her license.

Quoting from a recent paper by Elizabeth Ferguson: "Of the two aspects of supervision, the teaching and the law enforcing, the former should be the most in evidence. After patient teaching and demonstration then steps can usually be taken to enforce the existing law. The offending midwife is usually asked to retire as this is preferable to court action."

Wherever a real effort has been made to license only those midwives qualified according to local laws to practice, that goal has been achieved and those enforcing the law are willing to carry the responsibility for enforcement. In New York City, for example, in 1919 there were 1,700 midwives attending 40,000 or 30 per cent of the live births annually. In 1929, there were about 1,200 midwives attending 12,000 or 12 per cent of the live births. In 1939, there were less than 300 midwives attending about 2 per cent of the live births. In 1911, the Bellevue School for Midwives was founded and financed by city tax funds to supply midwives to care for the poor mothers of the city in their homes. An old report of their work cites a series of 10,740 deliveries with only four maternal deaths, one of which was due to pneumonia. It would seem that their work must have been well done and well supervised. The closing of this school in 1932 was no reflection on the midwives' work nor on the school, for coincident with the decrease in this midwife group was a similar increase in hospital facilities for Maternity Care; until today in New York City 95 per cent of our maternity patients are cared for in hospitals, and the facilities are adequate in quantity at least to care for every woman.

The recently quoted maternity mortality rate of 3.5 for the city is a credit to all who helped achieve it. This example I quote is a great city, and, if I know

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my audience, some of you are saying—but New York is not America. Let me remind you that the sages in public health administration in the last edition of the Appraisal Form have come to the conclusion that the organized services set up for handling these problems vary only in details—the principles of good public health service are applicable to rural and city areas alike. So I deduce from the various reports that have been made that the principles of safe Maternity Care are applicable in rural and city communities alike. This untrained, uneducated midwife is not equal to her task. She belongs to an inarticulate group which deserves thanks for the good deeds it has done, but it is a group of untrained women who are just not good enough to serve the mothers of this country when professional assistance can be secured. It is to be hoped that future programs which license the untrained midwife will provide for her patients at least some form of organized medical safeguards, such as the careful selection by medical examination of her patients, assistance with her problems and help in all emergencies, a plan for repairing lacerations when necessary and for giving the necessary postpartum and newborn care to the mother and baby. To give less than this is to ignore the essentials of safe care. Give her this help and sooner or later her work will gradually be taken over by the physicians and nurses.

I cannot leave the subject of the untrained midwife without drawing attention to the illegal abortions done by her. According to reports, some midwives have quite a flourishing abortion practice. This, too, might be considered a result of ignorance, an emotional attitude toward neighbors and friends, or perhaps a desire or need for money. Whatever the reasons for it, a way must be found to stop this illegal and destructive practice.

Let us not forget when talking about midwifery in America that we are talking about those who give care to about 225,000 women and their babies each year. That is not a small number. It is more than are born in an entire year in Sweden, for instance, whose health program we have quoted so often, and it is one-tenth of the babies born in this country every year. So the "midwifery problem", as it is so tritely spoken of by many, is not really a midwife problem at all. It is a problem rather of 225,000 mothers who get along as best they can without medical aid of any kind and are forced to depend upon the ministrations of these entirely untrained women. And it is well to remember that if these untrained midwives were not permitted to practice—say tomorrow—there is no one on the horizon at the moment to take their place. So they fill a need as best they can, but their best is not too good.

Now there is the nurse-midwife that others may have visualized at the mention of American midwife. While still few in number in this country, the nurse-midwife is directly and indirectly influencing the quantity and quality of the nursing care given to obstetric patients, particularly in home services. She has first studied and graduated from a school of nursing, then had some years practicing nursing, usually in the field of public health nursing; then studied midwifery under the direction of obstetricians and graduated.

This second group of women, for the time being, are called nurse-midwives. One of their greatest handicaps is their title. There is no point making any bones about it; to some people the very word is like a red rag to a bull. They need another name which describes their functions more acceptably to the public as well as to the profession and which leaves the person who uses the title or who hears it used free from prejudice. Our medical and nursing education service programs have in the past borrowed from the English and Continental schools but never their system of training or utilizing the services of the midwife. This is probably not a mistake in the light of modern obstetric practice. The

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European system placed a heavier responsibility upon the midwife than the education which they provided her justified and left her to practice in far too many instances without adequate medical supervision and direction.

Medical and nursing educational systems in the United States and Canada rejected the idea of educating and using the services of the trained midwife. They have developed instead an ideal plan which calls for medical care for every patient, a scheme which if expertly carried out is far-sighted and has great possibilities for life saving, for illness and disability prevention, and for meeting the needs of the mother and baby. This plan fixes the full responsibility for planning and for carrying out the plan for patients' care upon the physician, leaving him free to utilize the resources which are available or which can be developed. Good maternity hospitals have worked out pretty definitely the responsibilities of the different cooperating groups which help the doctor do his work. These include the work of the junior physicians, medical students, nurses, and nursing students, technicians, and social workers. The doctor alone could not make the ideal hospital what it is today and he would not try. If we could turn back the clock of time for 25 years and perfect our home service as we have done our hospital services, what would we see today? A good many years ago, Carolyn Van Blarcom said, "What we need is not that the high peaks of obstetric work in this country shall be made higher—but that the average of care given to all patients shall be raised." She went on to say that "The last word in safeguarding mothers and babies in this country shall not be said until in every state there is adequate provision for training and for controlling all who attend these patients no matter by what name they be called, nor until it is made impossible for untrained, incompetent practitioners to care for maternity patients habitually and for gain."

The nurse's responsibility for doing her part to raise this average of nursing care has been challenged, and, in my opinion, every nursing program must have for one of its objectives the creation of a wide-spread attitude of respect for all necessary work involved in the care of maternity patients in their homes. The public health nurse shares her work with the practical nurse, the neighbor, the family, and sometimes the so-called midwife. Lines of professional care are not easily drawn under home conditions, for who is to say when first aid will be needed in any home in which a mother is pregnant, especially as the pregnancy draws near the end, or if labor starts with one of its mysterious and different courses? The bulk of nursing care of mothers confined at home is not being done by the professional nurse. Where her services have been utilized, her time is limited and the work is still shared. Nursing in the United States has never developed a clear attitude toward the professional responsibilities which might be considered as minimal essentials for the care of every patient nor has it gone out and crusaded on a broad front for help to do this task. I do not mean to belittle the efforts made by the profession, but it is clear to all who study, that the European system assures every mother of some nursing care given by the trained midwife. The American way offers no such minimum of guarantee. The last eight years have made some difference in our thinking along these lines as public health nurses, and in our hopes and plans for the future. It is opportune now to say, if public health nursing is to continue to play an increasingly important part in the Maternal Care program, nurses can no longer go on in the same old way, giving poorly distributed care of variable quality and uneven quantity to communities and to individuals. We must study again what needs to be done and determine to nurse the maternity patient using either the public health nurse or a combination of the services of the nurse-midwife, the public health nurse, and the practical nurse. If this takes us into new responsibilities and adjusted functions, what difference does it make if

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we do well what needs to be done as part of a carefully thought-through medical plan? A few years ago, if anyone had told us that public health nurses would be taking Wassermann tests and giving intramuscular injections in our syphilis clinics, we would have said, "No! that is practicing medicine," but now the nurse helps the doctor and we even admit this fact in classroom discussions. And so it was with temperature taking, blood pressure readings, and many treatments. Public health nurses have done so-called educational work and many of them have lost their perspective and their arts of nursing. What a pity, when these arts are so badly needed!

Public health nursing organizations have been faced with real difficulties in getting nurses adequately prepared in obstetrics who are at the same time willing to take their share of day and night home delivery service. Some have solved the problem by bringing in young graduates. They are amenable to time schedule adjustments, etc. and they are also eager to learn public health nursing. It will not do for public health organizations to buy an intermittent variety of maternity nursing service from private duty nurses who have had no public health teaching and are not well qualified for obstetric nursing and use them to specialize the delivery and postpartum visits services. If we do these things, let us recognize them as palliative measures, or public health nursing will lose a great opportunity to nurse the maternity patients who need them.

Here in America the Frontier Nursing Service has shown how organized services of public health nurse-midwives can function in a rural area. Their excellent results and their practical nursing and educational efforts have shown one way to get nursing care to the American Frontier. Perhaps not everyone will look at the work of the Frontier Nursing Service and feel that stations like these should be developed throughout the country. No one can deny, however, that there is a real need for experimental work and for studies and reports of ways and means of giving adequate nursing care to maternity patients in their homes. One such study is that the clinic and school administered by the Maternity Center Association in New York City. Its primary purposes are:

1. To study a field situation in which the care of the maternity patient is given by the obstetrician who delegates responsibilities to the nurse-midwife. This study is being carried out to define methods and to study and test the results of the work, while maintaining throughout a high grade of care to the patient.
2. To train a limited number of selected public health nurses who can find a place to use their training in the newer order; not to work as private practitioners or midwives but as instructors and supervisors for the untrained midwives and for nurses with only an elementary or deficient training in obstetric nursing.

As early as 1911, old records show that some thinking along these lines had been done, but the chief stumbling block to progress and to experimental work was the unwillingness of the public health nursing leaders to cooperate in such a study. In 1923, a conference of nationally representative obstetricians and public health nursing executives met at the call of the Maternity Center Association to consider the desirability of developing a training center for nurse-midwives in order to study their value and determine desirable relationships. This conference indicated that even though everyone admitted available Maternity Care to be poor and the plan to have virtue worthy of a tryout, fear of medical-nursing relationships made the nursing representatives hesitant to lend the support of the then young public health nursing movement. By 1932 a beginning was made, however, in a small outdoor maternity service in New York City, in Harlem, in one of the poorest districts, having a high birth and death rate and poor housing conditions.

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From 30 to 50 per cent of the mothers had hemoglobin readings of under 70 as measured by the Sahli test.

Medical service was needed for repair of lacerations as follows: 1 in every 14 patients had 1° laceration repaired; 1 in every 60 patients had 2° laceration repaired; 1 in every 1366 patients had 3° laceration repaired.

If *nurse-midwives* cannot function without medical direction and aid, the conclusion is obvious that no untrained midwife should be allowed to do so.

This school has 45 alumnae at work in the United States, attempting to use what is practical from the program of the school. They do not pose as experts in obstetrics, rather they are at best only careful conscientious routine assistants to the physician. None would attempt or pretend to be more. It is utterly impossible for them to work without medical direction, for they have been trained to work only under medical supervision. Several have tucked away the title of midwife as in some situations it would be far more of a handicap than a help because of the prejudice the title arouses among nurses, doctors, and the lay people alike.

So I would conclude:—

1. The use of the specially trained obstetric nurse or nurse-midwife has been shown to be safe and feasible.

2. Every effort should be made to make safe care available for every mother as soon as possible.

3. All methods in operation should be carefully studied in relation to result and local need.

4. So long as patients will be confined at home, and nearly a million are each year, they should be nursed and nursed adequately by nurses who know obstetrics.

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